STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 310038	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADSTEP-WISCONSIN, INC (BLUEMOUND)	**101 N 75TH ST , MILWAUKEE, Wisconsin, 53213**

(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) COMPLETION DATE
N0000	Initial Comments On 09/02/2026, Surveyor completed an abbreviated survey and 2 complaint investigations at Broadstep - Wisconsin, INC (Bluemound). As a result, 10 deficiencies were identified. One of 2 complaints was unsubstantiated. One of 2 complaint was substantiated. Census: 7	N0000		
N0219	Licensee conduct caregiver background check 83.17(1) Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the provider did not ensure caregiver background checks were completed every 4 years for 1 of 1 (Lead Direct Support Professional B) caregiver who was employed for at least 4 years. Lead Direct Support Professional B did not have a background check completed at least every 4 years. Findings include: On 09/02/2026 at approximately 6:30 AM, Surveyor reviewed Lead Direct Support Professional B's	N0219		

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

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N0219	Continued from page 1 record. Lead Direct Support Professional B was hired on 05/02/2022. Lead Direct Support Professional B's original background information disclosure (BID) was dated 04/28/2022, Department of Justice check (DOJ) was dated 04/28/2022, and Governmental Findings Report was dated 04/28/2022. Lead Direct Support Professional B's record did not include a review that indicated Lead Direct Support Professional B's BID, DOJ, or Governmental Findings Report were reviewed on or before 04/28/2026. On 09/02/2026 at 1:45 PM, Surveyor interviewed Program Manager A and Administrator D. Program Manager A acknowledged Lead Direct Support Professional B's BID, DOJ, and Governmental Findings Report was not completed and/or reviewed on or before 04/28/2022. Program Manager A disclosed human resources identified that Lead Direct Support Professional B's complete background check should have been reviewed on or before 04/28/2022 as they were providing this Surveyor with Lead Direct Support Professional B's complete background check.	N0219		
N0277	Continuing education 83.25 The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview, the provider did not ensure 2 of 3 employees reviewed (Lead Direct Support Professional B and Direct Support Professional C) received 15 hours per calendar year of continuing education beginning with the first calendar year of employment including standard precautions, resident rights, fire safety and emergency procedures.	N0277		

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N0277	Continued from page 2 Lead Direct Support Professional B did not complete annual training in resident rights in 2025. Direct Support Professional C did not complete annual training in fire safety in 2024. Direct Support Professional C did not complete annual training in standard precautions, resident rights, fire safety, and emergency procedures in 2025. Findings include: On 09/02/2026, Surveyor reviewed employee files. The following was identified: Lead Direct Support Professional B was hired on 05/02/2022. Lead Direct Support Professional B's record did not indicate Lead Direct Support Professional B completed annual training in resident rights in 2025. Direct Support Professional C was hired on 10/23/2023. Direct Support Professional C's record did not indicate Direct Support Professional C completed annual training in fire safety in 2024. Direct Support Professional C's record did not indicate Direct Support Professional C completed annual training in standard precautions, resident rights, fire safety, and emergency procedures in 2025. On 09/02/2026 at approximately 1:45 PM, Surveyor interviewed Program Manager A and Administrator D. Administrator D disclosed he/she would review each caregiver's training to see if he/she could locate each training. Surveyor asked that Administrator D e-mail this Surveyor by the end of day on 09/02/2026 if he/she does locate each training. As of 09/03/2026 at 1:30 PM, Surveyor has not received any additional documents.	N0277		
N0352	Rights of Residents: Receive medication 83.32(3)(h) In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is	N0352		

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N0352	Continued from page 3 court ordered. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the provider did not ensure all medications were administered at the dose prescribed for 2 (Resident 1 and Resident 3) of 3 residents reviewed. Resident 1's January 2026 medication administration record (MAR) indicated Resident 1 was not given or offered his/her medications on 75 occasions. Resident 3's January 2026 MAR indicated Resident 3 was not given or offered his/her medications on 9 occasions. Findings include: On 01/28/2026, the department received a complaint alleging caregiver misconduct. On 09/02/2026 at approximately 7:00 AM, Surveyor reviewed the provider's misconduct incident report, dated 02/05/2026. The misconduct report stated, "On 01/25/2026, [Direct Support Professional C] ...punched out at 1515 (3:15 PM). The individual that was scheduled to work from 2100 (9:00 PM) to 0700 the next morning punched in at 2115 (9:15 PM). [Direct Support Professional C] did not notify the Operations Coordinator, the Program Manager, or the Administrator on Call that [he/she] was leaving the residence unattended ...[Resident 3] did not receive [his/her] 1700 Glipizide as it was too late to give it to [him/her] at 2130 (9:30 PM). [Resident 1] did not receive [his/her] 1600 (4:00 PM) Furosemide ..." On 09/02/2026 at approximately 12:00 PM, Surveyor reviewed resident records. The following was identified: Resident 1 was admitted on 11/22/2023. Per Resident 1's individual service plan, which was not dated, Resident 1 relied on facility staff to administer and manage his/her medications. Resident 1's file contained the following physician orders:	N0352		

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N0352	Continued from page 4 Amantadine 100 milligram capsules - take 1 tablet twice daily, 8:00 AM and 8:00 PM Aripiprazole 15 milligram tablets - take 1 tablet at bedtime, 8:00 PM Aspirin 81 milligram tablets - take 1 tablet at 8:00 AM Atorvastatin 20 milligram tablets - take 1 tablet at bedtime, 8:00 PM Carvedilol 12.5 milligram tablets - take 1 tablet at 8:00 AM and 5:00 PM Divalproex extended-release 250 milligram tablets - take 1 tablet at 8:00 PM Fluphenazine 5 milligram tablets - take 3 tablets at 8:00 AM and 8:00 PM Furosemide 40 milligram tablet - take 1 tablet at 8:00 AM and 4:00 PM Glipizide - take 1 tablet at 8:00 AM Haloperidol 10 milligram tablets - take 1 tablet twice a day, 8:00 AM and 8:00 PM Haloperidol 5 milligram tablets - take 1 tablet twice a day, 8:00 AM and 8:00 PM Lisinopril 2.5 milligram tablets - take 1 tablet at 8:00 AM Lokelma 5-gram powder packets - take 1 gram with one 16 ounce of water and drink at 8:00 AM and 4:00 PM Magnesium Lactate 84 milligrams - take 1 tablet at 8:00 AM	N0352		

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N0352	Continued from page 5 Melatonin 3 milligram tablets - take 1 tablet at 8:00 PM Metformin 1000 milligram tablets - take 1 tablet at 8:00 AM and 5:00 PM Pantoprazole 40 milligram tablets - take 1 tablet at 8:00 AM Spironolactone 50 milligram tablet - take 1 tablet at 8:00 AM Trazodone 300 milligram tablet - take 1 tablet at 8:00 PM Resident 1's January 2026 MAR indicated the following medications were not administered or offered as there were no initials stating the medications were given and/or offered. Amantadine: 8:00 AM: 01/11/2026, 01/17/2026 8:00 PM: 01/03/2026, 01/24/2026 Aripiprazole: 01/03/2026, 01/24/2026 Aspirin: 01/11/2026, 01/17/2026 Atorvastatin: 01/03/2026, 01/24/2026, 01/25/2026 Carvedilol: 8:00 AM: 01/11/2026, 01/17/2026 5:00 PM: 01/03/2026, 01/11/2026, 01/16/2026, 01/18/2026, 01/24/2026 Divalproex: 01/03/2026, 01/24/2026 Fluphenazine: 8:00 AM: 01/11/2026, 01/17/2026 8:00 PM: 01/03/2026, 01/09/2026, 01/24/2026	N0352		

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N0352	Continued from page 6 Furosemide: 8:00 AM: 01/11/2026, 01/17/2026 4:00 PM: 01/03/2026, 01/11/2026, 01/16/2026, 0/18/2026, 01/24/2026, and 01/25/2026 Glipizide: 01/11/2026, 01/17/2026 Haloperidol 10 milligram: 8:00 AM: 01/11/2026, 01/17/2026 8:00 PM: 01/03/2026, 01/24/2026 Haloperidol 5 milligram: 8:00 AM: 01/03/2026, 01/11/2026, 01/17/2026 8:00 PM: 01/03/2026, 01/24/2026 Lisinopril: 8:00 AM: 01/03/2026, 01/11/2026, 01/17/2026 4:00 PM: 01/03/2026, 01/11/2026, 01/16/2026, 01/17/2026, 01/18/2026, 01/24/2026, 01/25/2026 Magnesium: 01/11/2026, 01/17/2026 Melatonin: 01/03/2026, 01/24/2026 Metformin: 8:00 AM: 01/03/2026, 01/11/2026, 01/17/2026 5:00 PM: 01/03/2026, 01/11/2026, 01/16/2026, 01/17/2026, 01/18/2026, 01/24/2026, 01/25/2026 Pantoprazole: 01/03/2026, 01/11/2026, 01/17/2026 Spironolactone: 01/03/2026, 01/11/2026, 01/15/2026, 01/17/2026, 01/18/2026 Trazodone: 01/03/2026, 01/15/2026, 01/24/2026	N0352		

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N0352	Continued from page 7 Resident 3 was admitted on 11/20/2023. Per Resident 3's individual service plan, which was not dated, Resident 3 relied on facility staff to administer and manage his/her medications. Resident 3's file contained the following physician orders: Glipizide - take 1 tablet at 8:00 AM and 5:00 PM Levothyroxine 88 micrograms - Take 1 tablet at 8:00 PM Metformin extended-release 500 milligrams - Take 1 tablet at 8:00 AM Resident 3's January 2026 MAR indicated the following medications were not administered or offered as there were no initials stating the medications were given and/or offered. Glipizide: 8:00 AM: 01/11/2026, 01/17/2026 5:00 PM: 01/11/2026, 01/18/2026, 01/24/2026, and 01/25/2026 Levothyroxine: 01/16/2026 Metformin: 01/11/2026, 01/17/2026 On 09/02/2026 at approximately 1:45 PM, Surveyor interviewed Program Manager A and Administrator D. Program Manager A and Administrator D acknowledged the missing initials. Program Manager A and Administrator D were only aware of afternoon/night medications not being given on 01/25/2026, as that is when a caregiver reportedly left the residence prior to the next caregiver coming in for their shift. Administrator D stated he/she would start working with staff on the identified deficiencies. Cross Reference N0396 DHS 83.36(1)(a) Adequate Staff to Meet Resident Needs	N0352		

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N0387	Service plan development: parties involved 83.35(3)(b) Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the provider did not have the resident or resident's legal representative sign the Individual Service Plan (ISP) acknowledging their involvement in, understanding of, and agreement with the plan for 2 of 3 residents (Resident 1 and Resident 3) reviewed. Resident 1's and Resident 3's ISP did not have all required signatures. Findings include: On 09/01/2026 at approximately 10:00 AM, Surveyor reviewed resident records. The following was identified: Resident 1 was admitted on 11/22/2023. Resident 1's record indicated Resident 1 had an activated power of attorney for healthcare (POA-HC) document. Resident 1's record contained an ISP that was undated. The ISP did not contain signatures from Resident 1's POA-HC agent or a staff member from the Community Based Residential Facility (CBRF). Resident 3 was admitted on 11/20/2023. Resident 3's record indicated Resident 3 was their own decision maker. Resident 3's record contained an ISP that was undated. The ISP did not contain	N0387		

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N0387	Continued from page 9 signatures from Resident 3 or a staff member from the Community Based Residential Facility (CBRF). On 09/02/2026 at approximately 1:45 PM, Surveyor interviewed Program Manager A and Administrator D. Program Manager A disclosed the program manager, facility's case manager, and facility's nurse will meet to review each resident before developing a care plan. After each meeting, the case manager will then develop the resident's care plan. Once the care plan is developed, the case manager will email the care plan to the resident's legal representative and/or the resident, if they are their own legal decision maker. Program Manager A reported Resident 1's and Resident 3's ISP was developed on 03/28/2026, and the ISP that was provided to the Surveyor was the current ISP for each resident. Program Manager A confirmed a case manager met with Resident 3 regarding their ISP, however, Resident 3 was not in agreement with the care plan at that time, and Resident 3 refused to sign the ISP. Program Manager A reported the case manager was still working on Resident 3's ISP. Program Manager A could not confirm if Resident 1's POA-HC agent was provided with a copy of Resident 1's ISP.	N0387		
N0389	Service plans updated annually or on changes 83.35(3)(d) 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 LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 (Resident 1 and Resident 2) residents reviewed had an updated individual service plan (ISP) when there was a change in her/his needs. Resident 1's ISP did not address Resident 1's enrollment onto hospice services.	N0389		

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N0389	Continued from page 10 Resident 2's ISP did not address Resident 2's care team's responsibility in managing and administering Resident 2's prescribed medications. Findings include: On 09/01/2026 at approximately 10:00 AM, as Surveyor reviewed resident records, Program Manager A informed Surveyor Resident 1 received hospice services through Aurora at Home and Resident 2's care team managed and administered all of Resident 2's prescribed medication(s). On 09/01/2026 at approximately 10:00 AM, Surveyor reviewed resident records. The following was identified: Resident 1 was admitted on 11/22/2023. Resident 1's record contained an ISP that was undated. Resident 1's ISP did not address Resident 1's enrollment onto hospice services, nor did it include the services hospice staff would provide. Resident 2 was admitted on 09/03/2025. Resident 2's record indicated Resident 2 had a care management team. Resident 2's ISP, with a signature date of 12/05/2025 indicated facility staff administered and managed Resident 2's medications and not Resident 2's care management team. On 09/02/2026 at approximately 1:45 PM, Surveyor interviewed Program Manager A and Administrator D. Program Manager A reported Resident 1's ISP was developed on 03/28/2026. Program Manager A confirmed the ISP that was provided to this Surveyor was Resident 1's current ISP. Program Manager A disclosed Resident 1 was enrolled in hospice during the week of 08/17/2026, but understood, Resident 1's care plan should address Resident 1's hospice enrollment. Program Manager A disclosed he/she would work with the facility's case manager to have all ISPs updated with the resident's current needs and services.	N0389		
N0396	Adequate staff to meet resident needs. 83.36(1)(a)	N0396		

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N0396	Continued from page 11 The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the provider did not ensure there was an adequate number of caregivers working on a 24-hour basis to meet the needs of 3 of 3 (Resident 1, Resident 2, and Resident 3) residents reviewed. Residents were left unsupervised for a total of 6 hours. This resulted in missed medications, a resident cooking dinner for all residents, and unlimited access to an unlocked medication closet. Findings include: The provider was licensed to care for a maximum of 8 residents in the client groups of developmentally delayed and emotionally disturbed/mental illness. On 1/28/2026, the Department received a complaint alleging a caregiver left the residents unsupervised. On 09/02/2026 at approximately 7:00 AM, Surveyor reviewed the provider's misconduct incident report, dated 02/05/2026. The misconduct report stated: "On 01/25/2026, [Direct Support Professional C] was scheduled to work from 0700 to 1500 (3:00 PM). Shortly before 1500 the staff that was scheduled to work at 1500 called off for that shift. At 1500 [Direct Support Professional C] called Central Scheduling to ask who was coming to relieve [him/her]. [He/She] was told [his/her] relief would be there at 2100 (9:00PM). [He/She] told them [he/she] had to leave to go to another job. [He/She] was advised that Central Scheduling would try to find coverage but [he/she] needed to stay. [He/She] punched out at 1515 (3:15 PM). The individual that was scheduled to work from 2100 to 0700 the next morning punched in at 2115 (9:15 PM). [Direct Support Professional C] did not notify the Operations Coordinator, the Program Manager, or the Administrator on Call that [he/she] was leaving the residence unattended."	N0396		

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(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) COMPLETION DATE
N0396	Continued from page 12 "Describe the effect that the incident had on the affected person ...One of the clients realized that staff had left and made dinner for all of the residents. [Resident 3] did not receive [his/her] 1700 (5:00 PM) Glipizide as it was too late to give it to [him/her] at 2130 (9:30 PM). [Resident 1] did not receive [his/her] 1600 (4:00 PM) Furosemide ..." On 09/02/2026 at approximately 9:45 PM, Surveyor reviewed Program Manager A's e-mail to the provider's administration staff. The e-mail stated the following: "I received a call on 1/25/26 at 9:31 PM from staff [Direct Support Professional E] and Central Scheduling stating, "there was no staff at Bluemound when [Direct Support Professional E] arrived at 9:30 PM." [Direct Support Professional E] reported, "Meds were left on the desk, all med cabinets were unlocked, could not find the keys. Resident was locked in room and smoking. I informed [Direct Support Professional E] were (sic) the extra keys were. [Direct Support Professional E] asked the resident if they had the keys? They did and gave them to staff ..." On 09/01/2026 at approximately 10:00 AM, Surveyor reviewed resident records. The following was identified: Resident 1 was admitted to the home on 11/22/2023. Resident 1's record contained an ISP that was undated. Per Resident 1's ISP, Resident 1 relied on staff to prepare all meals and administer all prescribed medications. Resident 2 was admitted to the home on 09/03/2025. Resident 2's ISP with a signature date of 12/05/2025 indicated Resident 2 relied on staff to prepare all meals. Resident 3 was admitted to the home on 11/20/2023. Resident 3's record contained an ISP that was undated. Per Resident 3's ISP, Resident 3 relied on staff to prepare all meals and administer all prescribed medications. On 09/01/2026 at approximately 12:00 PM, Surveyor interviewed Program Manager A. Program Manager A	N0396		

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N0396	Continued from page 13 confirmed [Direct Support Professional C] left the residents unattended. Program Manager A reported all residents within the home relied on staff to prepare and cook all meals. Program Manager A disclosed no residents should be cooking meals. Program Manager A stated Resident 5 had the keys to the medication closet upon Direct Support Professional E's arrival to the facility. Program Manager A stated Resident 5 cooked hamburgers in the oven for each resident. Program Manager A was not aware Resident 5 placed cooking oil on the baking sheet and placed the hamburgers on the baking sheet, until the next day, as the first shift caregiver turned the oven on, and the house became very smoky. Program Manager A acknowledged no residents should have access to the keys for the medication closet. On 09/02/2026 at approximately 1:45 PM, Surveyor interviewed Program Manager A and Administrator D. Administrator D denied any system policies changed as a result of the above incident as Direct Support Professional C did not follow the protocol that was in place. Administrator D disclosed Direct Support Professional C should have contacted Program Manager A or the on-call administrator. Administrator D stated Program Manager A or the on-call administrator would have come in to complete the shift or until a replacement caregiver could come in. Surveyor informed Program Manager A and Administrator D of the potential risks and negative outcomes that were identified once Direct Support Professional C left the home. The risks identified were the potential for a fire (Resident 5 cooking hamburgers in cooking oil in the oven and smoking in their bedroom) and a resident having full/unsupervised access to the medication closet. The negative outcome identified was that two residents were not afforded the opportunity to take their prescribed medications. Program Manager A and Administrator D acknowledged the risks and negative outcomes that were present once Direct Support Professional C left the home unsupervised. Cross Reference N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication	N0396		
N0433	Behavior management. 83.38(1)(i)	N0433		

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N0433	Continued from page 14 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 LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, record review and interview, the provider did not provide services to manage behaviors that may be harmful to others for 1 of 3 residents reviewed (Resident 1). The provider did not provide or arrange services to manage Resident 1's verbally aggressive behavior towards Resident 3 and Resident 4. Findings include: The provider is licensed as a Class AA (ambulatory) facility to care for 8 residents in the client groups of developmentally disabled and emotionally disturbed/mental illness. On 09/01/2026, the facility census was 7. On 09/01/2026, between 8:30 AM and 12:00 PM, Surveyor observed Resident 1 yelling at Resident 3 and Resident 4 and calling Resident 3 and Resident 4 derogatory names. Surveyor observed Direct Support Professional F attempt to redirect Resident 1 multiple times, however, Resident 1 was not always redirectable, or would stop yelling at Resident 3 for a Resident 4 for a moment but would return to yelling at or calling Resident 3 and Resident 4 derogatory names. On 09/01/2026 at approximately 11:00 AM, Surveyor reviewed a document on the kitchen wall that stated, " ...Sometimes [Resident 1] will be verbally abusive to other clients as well as staff you can ask [him/her] to be polite or talk about things [he/she] likes to redirect the conversation." On 09/01/2026 at approximately 11:26 AM, Surveyor	N0433		

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N0433	Continued from page 15 interviewed Resident 3. Resident 3 reported Resident 1 calls him/her racial slurs every day, all day. Resident 3 stated Resident 1 screams all throughout the night, that Resident 3 can not sleep. Resident 3 disclosed talking with Resident 1's primary care physician about the constant yelling and Resident 1 calling Resident 3 derogatory names. Resident 3 stated Resident 1's yelling is "intolerable." On 09/02/2026 at approximately 12:00 PM, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 11/22/2023. Per Resident 1's individual service plan, which was not dated, Resident 1 "...occasionally struggles with social awareness." The goal identified for this concern was, "[Resident 1] will engage in respectful conversations using [his/her] indoor voice and appropriate language." The interventions identified was, "Staff will provide gentle, in-the-moment redirection when [Resident 1] uses profanity, encouraging [him/her] to rephrase [his/her] thoughts using appropriate language ..." Resident 1's record included a behavioral support plan (BSP), with a start date of 05/23/2025. The "historical behavior" that was identified was, "[Resident 1] has exhibited outgoing behavioral challenges that include frequent verbal aggression and episodes of spitting, particularly when redirected or upset. She can become verbally disrespectful toward both staff and peers ..." The intervention identified for this behavior included the following: "Staff will help redirect [Resident 1] to use indoor voice/volume. Staff will remove [him/her] from the situation or conversation for [him/her] to take 5 minutes to cool/calm down ..." On 09/02/2026, Surveyor interviewed Program Manager A and Administrator D. Program Manager A confirmed Resident 1's behavior is not acceptable, and Resident 1 should not be yelling racial slurs towards Resident 3 or calling Resident 3 and Resident 4 derogatory names. Program Manager A reported having a conversation with Resident 1's care team due to Resident 1 continuously yelling at Resident 3 and Resident 4, however, has not received any guidance from Resident 1's care team. Program Manager A and Administrator D stated they would meet with Resident 1's care team again and discuss possibly Resident 1 needing a higher level of care.	N0433		
N0526	Other evacuation drills. 83.47(2)(e)	N0526		

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N0526	Continued from page 16 Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This LICENSURE REQUIREMENT 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 (2024 and 2025) of 2 years. Findings include: On 09/01/2026 at approximately 8:30 AM Surveyor reviewed the provider's other evacuation drills for 2024 and 2025. The following was identified: 01/16/2024: Tornado Drill 05/15/2025: Tornado Drill The provider did not complete other evacuation drills during the second half of 2024 and 2025. On 09/01/2026 at approximately 12:00 PM, Surveyor interviewed Program Manager A. Program Manager A reported he/she is responsible for ensuring other evacuation drills are completed semi-annually. Program Manager A stated he/she tries to audit the facility's other evacuation drills annually, however, at times, may not always complete the annual audits. Program Manager A stated he/she would reeducate the facility staff on the need to complete other evacuation drills on a semi-annual basis.	N0526		
N0530	Fire inspection. 83.47(3) 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 LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the provider did not arrange for an annual fire inspection for 2 of	N0530		

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N0530	Continued from page 17 2 years reviewed (2024 and to date in 2026). Findings include: On 09/01/2026, at approximately 8:30 AM, Surveyor reviewed the facility safety file. A fire inspection was conducted on 08/04/2025. Surveyor did not locate evidence of a fire inspection conducted in 2024 and to date in 2026. On 09/01/2026 at approximately 12:00 PM, Surveyor interviewed Program Manager A. Program Manager A reported maintenance was responsible for ensuring all fire inspections were completed annually and on a timely basis. Program Manager A stated he/she would have a conversation with maintenance and e-mail any additional documents to this Surveyor. As of 09/02/2026, Surveyor received additional documents, however, the 2024 and 2026 fire inspections were not a part of the additional documents that were sent.	N0530		
N0532	Fire extinguishers: locations. 83.47(4)(b) A fire extinguisher shall be mounted on a wall or a post or in an unlocked wall cabinet used exclusively for that purpose. Fire extinguishers shall be clearly visible. The route to the fire extinguisher shall be unobstructed and the top of the fire extinguisher shall not be over 5 feet high. The extinguisher shall not be tied down, locked in a cabinet or placed in a closet or on the floor. Fire extinguishers on upper floors shall be located at the top of each stairway. Extinguishers shall be located so the travel distance between extinguishers does not exceed 75 feet. The extinguisher on the kitchen floor level shall be mounted in or near the kitchen. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation and interview the provider did not ensure 2 of 4 fire extinguishers were mounted on a wall or a post or in an unlocked wall cabinet. The fire extinguishers on the main floor and 2nd floor were stored inside a locked closet, preventing immediate access in an emergency.	N0532		

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N0532	Continued from page 18 Findings include: On 09/01/2026, at approximately 11:00 AM, Surveyor toured the facility with Program Manager A. Surveyor observed 3 fire extinguisher mounting brackets to be without a fire extinguisher. One empty mounting bracket was in the kitchen, and the second empty bracket was in the hallway leading to the second floor. The two fire extinguishers were in a locked closet near the resident bathroom, located on the first floor. Surveyor observed Program Manager A using a key to unlock the closet to show Surveyor where the fire extinguishers were kept. On 09/01/2026, as Surveyor toured the facility with Program Manager A, Surveyor interviewed Program Manager A. Program Manager A reported the two fire extinguishers were removed from the mounting bracket as a resident recently used the fire extinguisher to try and harm a staff member. Program Manager A understood all fire extinguishers should be mounted and easily accessible in the event of a fire. Program Manager A acknowledged that placing the fire extinguishers behind a locked door could delay a staff member's ability to quickly respond to a fire.	N0532		