STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445141	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bradley Health Care & Rehab	2910 Peerless Rd Cleveland, TN 37312

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on review of the facility policy, observation, and interview, the facility failed to remove resident plates and utensils from serving trays, to promote a dignified dining experience for 8 of 8 residents observed in the [NAME] 1 dining room and delayed assistance to 1 dependent resident (Resident #13) for 20 minutes who was seated at the same table as other residents received and finished their meals.The findings include: Review of the undated facility policy titled, Promoting/Maintaining Resident Dignity, revealed .It is the practice of this facility to .promote .and treat each resident with respect and dignity .care for each resident in a manner and in an environment, that maintains or enhances quality of life .Each Resident will be provided equal access to quality of care, regardless of diagnosis, severity of condition . Review of the medical record revealed Resident #13 was admitted to the facility 11/25/2025 with diagnoses including Adjustment-Disorder with Depressed Mood, Mild Cognitive Impairment, Generalized Anxiety, Unspecified Tremor, Moderate Malnutrition, and Muscle Weakness. Review of admission and Quarterly Minimum Data Set (MDS) assessments dated 11/25/2025, revealed Resident #13 scored a 14 on the Brief Interview for Mental Status (BIMS) assessment which indicated Resident #13 was cognitively intact. Continued review revealed Resident #13 required set up and supervision with eating. During multiple observations of Resident #13 and other peers seated in the main dining room on 5/18/2026 and 5/19/2026 during the lunch meal service, revealed on both dates, meals were served to residents atop service trays. The plates and utensils were not removed from the service trays throughout the meal. Resident #13 was observed on 5/18/2026 and 5/1/2026 seated at a time during the lunch meal and waited for over 20 minutes while others seated at the same table, received and finished their meals, before staff served and assisted Resident #13 with his meal. During an observation and interview on 5/19/2026 at 6:05 PM, in the dining room, Resident #13 was observed to have finished his meal, and sat at a table with another resident. Resident #13 stated he had frequently observed other residents being served their meals and had watched as the other residents sat at the same table consume the meals as he waited for assistance. Resident #13 (who was alert and oriented in all spheres) stated the practice of having to wait to be served and assisted with meals was customary for him and further stated .I am real easygoing, but sometimes it makes me feel left out . During interview on 5/19/2025 at 6:30 PM, the Director of Nursing (DON) confirmed the facility failed to maintain Resident #13's dignity, in accordance with expectations of the facility policy, during the meal services.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on review of the facility abuse policy, review of facility investigations, and interviews, the facility failed to ensure facility reported incidents (FRI) related to allegations of abuse were reported within a timely manner for 4 residents (Residents #1, # 2 #3 and #4) of 11 residents sampled for abuse or neglect.The findings included: Review of the facility policy and procedure Resident Abuse revealed .When an incident of suspected resident abuse, mistreatment, or neglect is reported the following will occur .The case of suspected abuse will be reported per regulation to the Department of Health by Administrator or Designee .If you have witnessed or have knowledge of such actions in this facility, please give an immediate report to Administration .Resident Abuse May Also Be Reported to . (State Agency) . (Ombudsman) . Review of the facility FRI (incident 2998873) dated 4/29/2026 revealed the incident referenced in the FRI included allegations of potential resident versus resident abuse, which was documented to have occurred on the evening of 4/28/2026 around 7:50 PM between Residents #1 and #2. Continued review of the documents revealed the allegations were received by the state agency on 4/29/2026 at 2:01 PM, 18 hours after the incident occurred. Review of facility FRI (incident 2998805) dated as received by the state agency on 4/29/2026 at 1:41 PM, showed the incident referenced in the FRI occurred on the evening of 4/23/2026 (6 days earlier), and included allegations of potential resident versus resident physical abuse between Residents #3 and #4. Continued review showed the facility abuse coordinator was not made aware of the allegations of potential resident on resident abuse, until the morning of 4/24/2026, (the day after the allegations were to have occurred) at which time the facility formally launched an investigation, which was not reported to the state agency until 5 days later. During interview on 5/19/2026 at 10:30 AM, the Director of Nursing (DON) confirmed the facility failed to report allegations related to potential resident versus resident abuse to the state agency within 2 hours of the facility becoming aware of them, as mandated by state and federal requirements for both incidents.

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F 0744 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, video surveillance footage review and interview, the facility failed to provide individualized behavioral interventions, and sufficient supervision to prevent wandering, and exit seeking behaviors, for 1 resident (Resident #1) of 4 residents reviewed for behaviors which resulted in actual Harm to Resident #1. ˆThe facility's failure to provide sufficient monitoring, supervision, and adequate care plan interventions in response to wandering and exit seeking behaviors, resulted in Resident #1 sustaining fall related injuries during a wandering episode on 4/28/2026. The findings include: ˆ Review of the facility's undated policy titled, Elopements and Wandering Residents, revealed .Residents determined to be at risk for elopement will be monitored by staff . ˆ Review of the facility's undated policy titled, Behavior Management Policy, revealed .It is the policy of [Named Facility] .to minimize challenging and inappropriate behavior .within the facility .so that all residents may enjoy a high level of satisfaction and quality of life .Behavior management .adjusting the environment to meet that resident's needs .should demonstrate a positive approach and be resident-centered .early intervention should be used to prevent behavior from escalating to a higher level .staff will intervene immediately at the first indication of escalating behavior .interventions may include .Distraction .attempt to redirect resident with alternative actions .re-direction .remove resident from the situation by turning towards another area, again offering alternatives .staff will assess resident to attempt to determine a trigger for the behavior .once need is determined .staff will facilitate meeting that need . ˆ ˆ Review of the medical record revealed Resident #1 was admitted to the facility 3/13/2026 with diagnoses including Dementia, Displaced Comminuted Fracture of Left Tibia, Closed Fracture with Routine Healing, Bipolar Disorder, Macular Degeneration, and Repeated Falls. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 scored a 3 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment. Continued review revealed Resident #1 had impaired thought processes and wandering behaviors 4 to 6 days weekly. ˆ Review of the Wandering Risk assessment dated [DATE], revealed Resident #1 scored a14 which was considered at high risk for wandering.ˆ Review of the admission care plan for Resident #1 dated 3/17/2026, revealed the resident had a diagnosis of Dementia and Bipolar Disorder with mood problems and Depression, which included interventions including .Administer medications as ordered .Encourage Resident to express feelings .Report .acute episode feelings or sadness Recommend behavioral interventions for staff . Resident has a mood problem r/t [related to] bipolar disorder .currently taking psychoactive meds .Briefly provide supporting listening/conversation the redirect to positive topic/activity . Continued review revealed an individualized person-centered care plan had not been developed or implemented with interventions in place to address Resident #1's dementia behaviors related to elopement risk factors and known history of wandering behaviors. Review of the fall risk assessment dated [DATE], revealed Resident #1 scored a 22 and was considered at high risk for falls. Review of a psychiatric periodic evaluation note dated 3/23/2026, revealed .[Resident #1 is seen today for reassessment of insomnia, anxiety, and restlessness, and sadness with tearfulness .melatonin [sleep aide] was restarted one week ago .Staff report patient [Resident #1] is still not sleeping very well. Patient more confused and more anxious with restlessness and agitation in the evenings and at night c/w [consistent with] sundowning [state of increased confusion, agitation, anxiety, and restlessness that occurs in the late afternoon and lasts into the night] .Today [Resident #1] is sitting on the side of her bed, eating lunch and visiting with her daughter who is sitting at the bedside .She is alert .interactive .calm .comfortable .She is confused and oriented to person only .she does not know who her daughter is .cognition is severely impaired .spoke with daughter at length today .she states patient has been more confused, more anxious, more sad, and more tearful since (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	admission .she states she [Resident #1] is not sleeping well and is often acting crazy at night .discussed recent anesthesia, recent moves from home to hospital to this facility, as well as having to take new pain medication for acute pain, all are likely causing .increased confusion, behaviors, anxiety and worsening mood .Patient is on medication for Bipolar or Delusional Disorder, Major Depressive Disorder with Psychotic Features, Adjunctive Treatment for Treatment-Resistant Depression, Parkinson's Disease Psychosis, Delirium, Brain Injury, or Dementia Related Indications .Gradual Dose Reduction of the patient's antipsychotic medication was not recommended or ordered during this visit . Review of the nurse's notes for Resident #1 dated 3/13/2026 - 4/13/2026, revealed Resident #1 fell on 3/13/2026, 3/22/2026, 4/2/2026, 4/10/2026, and 4/13/2026 which were most likely attributed to resident behaviors, confusion, and Dementia diagnosis. ˆContinued review revealed Resident #1 was transferred to a local hospital emergency department by ambulance on 4/13/2026 for treatment of lacerations and bruising to the forehead sustained from the fall on 4/13/2026. ˆ Review of the Pre-admission Screening and Resident Review (PASRR) Level 1 screening for Resident #1 dated 4/16/2026, revealed .Your [Resident #1] neurocognitive disorder/dementia, is so progressed that is considered to be the primary condition requiring treatment at the time of this review .and you are not likely to benefit from disability related services at this time . ˆ Review of the facility reported incident (FRI) investigation report dated 4/28/2026, revealed on 4/28/2026 Resident #1 entered Resident #2's room, undetected by staff, remained in the room for approximately 44 minutes, and was involved in a fall with injuries, which required emergent care to address the fall related injuries. ˆContinued review of the FRI revealed in response to the incident, a removeable door barrier (stop sign) was added to the doorway of Resident #2's room to prevent Resident #1 from wandering into the room again. ˆ Review of the FRI report and investigation notes for Resident #1 dated 4/28/2026, revealed the facility determined Resident #1 had fallen during a wandering episode in which the resident wandered from the hallway into Resident #2's room by wheelchair, closed the door, and remained in Resident #2's room for 44 minutes undetected by staff on the unit, until Resident #1 was found crawling on the floor out of the room, bleeding from the forehead. Trails of blood droplets found on the floor of the room, indicated Resident #1 had traversed Resident #2's room from the door to the window. Review of facility video surveillance footage of the incident time stamped 4/28/2026 from 6:19 PM until 7:45 PM, revealed Resident #1 was observed wandering about the unit seated in a wheelchair. Resident #1 was observed in the hallway, and began to push the wheelchair from behind, to the nurse's station where a staff member was seated and did not notice Resident #1 until the resident came into close proximity to the nurse's desk. The staff member redirected Resident #1 back to the wheelchair. Resident #1, who was seated in the wheelchair, proceeded to wander away from the nurse's station and was observed on the video footage to wander the hallway near the nurse's station and an exit door where visitors were entering and exiting the facility, without staff supervision or redirection. Continued review revealed at 6:49 PM, Resident #1 attempted to follow visitors out the door and was redirected away by the visitors. Staff present at the nurse's station and in the general vicinity of the resident continued their tasks, without redirecting the resident, as Resident #1 proceeded wandering to the [NAME] Hallway and away from the nurse's station. Resident #1 was then observed to test doors to the locked storage room and at 6:21 PM the resident opened the door to a charting kiosk, rolled inside the doorway, then backed out, as staff present on the unit continued their tasks, and did not redirect Resident #1's behaviors. Further review revealed Resident #1 was observed in the wheelchair and continued to wander in the [NAME] Hallway. At 6:53 PM, Resident #1 entered Resident #2's room, closed the door behind her, and went undetected or redirected by staff. Further review of the video footage from 6:53 PM to 7:37 PM (44 minutes), revealed multiple staff present on the unit carrying out various tasks. Staff appeared to be unaware of Resident #1's whereabouts, until 7:37 PM, when Resident #1 was seen crawling on the floor away from Resident #2's room, with blood visible on the forehead. 2 staff who were present in the hallway immediately responded to Resident #1, and after a brief assessment, (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	were observed running down the hallway towards the nurse's station.ˆ The 2 staff members who responded, left Resident #1 unattended by staff, still in the floor crawling and bleeding from the forehead. Approximately 1 minute later multiple staff were seen rushing to render aid to Resident #1. Continued review of the video footage revealed Emergency Medical Services (EMS) arrived approximately 4 minutes after the facility staff rendered aid to Resident #1.ˆThe video footage revealed EMS personnel transported the resident out of the facility on a gurney. Further review of the video footage revealed Resident #1 was observed with visible bruising and blood on the forehead as she was transferred to an ambulance outside. ˆ Review of the hospital records for Resident #1 dated 4/28/2026, revealed the resident was evaluated by the emergency physician who documented the bleeding on Resident #1's forehead was due to a reinjury of scabbed laceration sites (previously sutured) at the same local emergency department (ED) related to a fall sustained 2 weeks prior while at the facility. Resident #1 was released back to the facility for continued care after computer assisted tomography studies (CAT Scan) performed at the hospital ruled out acute head injuries. Review of psychiatric hospital records for Resident #1 dated 5/8/2026 - 5/11/2026, revealed Resident #1 was transferred from the facility to an acute mental health center for evaluation due to behaviors on 5/8/2026, (10 days after the facility reported incident) and was discharged back to the facility on 5/11/2026 for continued care after medication adjustments from the psychiatric hospital. ˆ Review of the comprehensive care plan for Resident #1 dated 5/18/2026, revealed the care plan had not been revised to address Resident #1's recent psychiatric hospitalization from 5/8/2026-5/11/2026, or new interventions to address Resident #1's behaviors, including the wandering behaviors demonstrated on 4/28/2026 with the subsequent fall. Continued review revealed no changes were documented in the care plan regarding the psychiatric hospital recommendations related to medication changes, or any additional new interventions added to the care plan to address Resident #1's frequent falls. ˆ During an interview on 5/18/2026 at 8:20 PM, Licensed Practical Nurse (LPN) A (the unit manager) stated she had provided care for Resident #1 since admission and was aware the resident was considered a high risk for falls. LPN A stated the resident had sustained multiple falls prior to 4/28/2026 due to poor safety awareness, severe cognitive impairment, non-compliance with safety measures, and behaviors related to the resident's Dementia diagnosis and was known to frequently wander. LPN A stated the resident's behaviors were worse in the evening or nighttime hours and staff usually monitored Resident #1 closely at the nurses' station or maintained the resident in close proximity to the nurse during medication rounds as an intervention for the wandering behaviors. LPN A further stated on 4/28/2026 at the time of the resident's fall, the nurse and staff had lost track of Resident #1's whereabouts while attending to other tasks. LPN A confirmed she and the facility staff on duty were not aware Resident #1 had wandered into another resident's room, had been left unattended for 44 minutes, and had fallen until Resident #1 was observed crawling out of the doorway out of the other resident's room on 4/28/2026. During an interview on 5/18/2026 at 3:49 PM, the Social Worker stated Resident #1 was admitted to the facility from a local hospital after the treatment for fall-related injuries sustained at home. The Social Worker stated Resident #1's family had not reported any behaviors of Resident #1 during the admission initial family interview or the care planning meetings. The Social Worker stated after admission to the facility, the resident began to exhibit wandering behaviors, had sustained several falls since admission to the facility, and was known to be combative with staff during ADL care. The Social Worker stated she had no explanation as to why Resident #1's diagnosis of Dementia with risk factors identified on the admission MDS assessment and the PASRR level one screening had not been developed or implemented on the resident's care plan. The Social Worker confirmed an individualized person-centered Dementia care plan for Resident #1's known high risk factors for falls, wandering and combative behaviors, or exit seeking and elopement risk behaviors, had not been developed or implemented with intervention on the care plan. During an interview on 5/18/2026 at 4:30 PM, the Director of Nursing (DON) confirmed the facility had not revised Resident #1's person-centered (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	behavioral care plan with interventions to address the resident's wandering behaviors, the intervention of using the stop sign after the incident on 4/28/2026, or the psychiatric hospitalization on 5/8/2026-5/11/2026 with appropriate interventions. During an interview on 5/18/2026 at 6:55 PM, the Director of Nursing (DON) confirmed the facility failed to develop and implement a person-centered Dementia care plan for Resident #1 with specific interventions to reduce the wandering and exit seeking behaviors. ^ During interview on 5/19/2026 at 10:30 AM the DON confirmed the facility failed to adequately supervise, monitor, and redirect Resident #1's behaviors on 4/28/2026. The DON confirmed the facility's failure resulted in the facility staff not having an awareness of Resident #1's whereabouts for approximately 44 minutes resulting in an unwitnessed fall with injury and transport to the local ED for evaluation and treatment.