STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525325	A. Building B. Wing	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bradley Estates Nursing and Rehab LLC	6735 W Bradley Rd Milwaukee, WI 53223

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47094 Based on interview and record review the facility did not ensure resident was free from misappropriation of property for 1 (R64) of 1 residents reviewed for misappropriation. * R64 had eight (8) oxycodone tablets go missing when facility staff did not complete a shift change narcotic count on 6/10/2024. The facility did not thoroughly investigate the missing narcotic tablets and the investigation did not include a conclusion of where the missing 8 oxycodone tablets went. Findings include: The facility policy entitled Abuse, Neglect and Exploitation revised on 1/5/2024 documents It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent, use of a resident's belongings or money without the resident's consent. Policy Explanation and Compliance Guidelines: 1. The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. b. Establish policies to investigate any such allegations. 3. The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written. II. Employee Training A. New employees will be educated on abuse, neglect, exploitation, and misappropriation of resident property during initial orientation. C. Training topics will include: (continued on next page)

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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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Prohibiting and preventing all forms of abuse, neglect, misappropriation, of resident property, and exploitation. III. Prevention of Abuse, Neglect, and Exploitation- the facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: . G. Addressing features of the physical environment that may make abuse, neglect, exploitation, and misappropriation of resident property more likely to occur. H. Assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors. V. Investigation of Alleged Abuse, Neglect, and Exploitation: . B. Written procedures for investigations include: . 4. Identifying and interviewing all involved persons, including alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. 6. Providing complete and through documentation of the investigation. 1.) R64 was admitted to the facility on [DATE] with a diagnosis that includes diabetes mellitus type 2, spinal stenosis, displaced comminuted fracture of right ankle anxiety disorder, vascular dementia, and major depressive disorder. R64's quarterly minimum data set (MDS) dated [DATE] indicated R64 had severely impaired cognition with a Brief Interview for Mental Status (BIMS) score of 5. Section H of the MDS- Pain Management, documents that R64 is on a scheduled pain medication regimen, receives PRN (as needed) pain medications and has pain assessments conducted. At the time of the assessment, the facility documented R64 did not have pain at any time in the last five days of when the assessment was conducted. The facility self-report documents that on 6/10/2024 the 3rd shift licensed practical nurse (LPN)-AA left the facility at shift change before counting narcotics with the oncoming first shift LPN-BB. The report documents the medication cart keys were left on the med cart in the nurse's station. When LPN-NN arrived to the facility to start 1st shift, LPN-BB did not count the narcotics with another nurse before starting the shift. The medication narcotics were not counted until 6/10/2024 at shift change for second shift. It was documented that R64 was missing 8 oxycodone 5 mg tablets from the medication card. The facility then started an investigation. Surveyor noted that other staff that worked on 6/10/2024 were not interviewed as part of the investigation. The facility self-report did not document when LPN-BB arrived at the facility and started to pass medications from the medication cart. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/2024, at 2:18 PM, Surveyor interviewed Director of Nursing (DON)-B. Surveyor asked DON-B if other staff were interviewed regarding R64's missing narcotics on 6/10/2024. DON-B stated that LPN-BB left the medication cart keys on the medication cart in the medication room, and that no one had access to the medication room. DON-B stated that the facility reviewed video footage and could not substantiate the medication card was removed. Surveyor asked DON-B what the time frame was between LPN-AA leaving the facility and LPN-BB arriving to the facility and starting medication pass. DON-B informed Surveyor she would review the investigation and let Surveyor know. Surveyor then requested the time slips for LPN-AA and LPN-BB. On 6/27/2024, at 8:00 AM, Surveyor interviewed LPN-CC who stated any nursing would have access to the medication rooms. LPN-CC stated that medication counts can be done with any nursing staff if the prior shift nurse is unavailable to count the narcotics with. On 7/1/2024, at 2:09 PM, Surveyor shared concerns with DON-B regarding the self- report for R64's missing 8 Oxycodone 5 mg tablets and that no other staff was interviewed to determine if they knew anything about the missing medications. No additional information was provided as to why the facility did that R64 was free from misappropriation of property after eight (8) oxycodone tablets went missing.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 42037 Based on record review, the facility did not properly complete a BID (Background Information Disclosure) form, DOJ (Department of Justice) form, and IBIS (Integrated Background Information System) form for 2 of 8 employees reviewed for the sufficient and competent staffing tasks. This has the potential to affect a pattern of residents whom may recieve care from both staff members. Findings include: On 6/27/24 at 8:11 AM, Surveyor reviewed CNA-KK's and Activity Aide-LL's employee files to validate that the facility completed a BID (Background Information Disclosure) form, DOJ (Department of Justice) form, and IBIS (Integrated Background Information System) form for upon hire and within the last 4 years. Surveyor noted: CNA-KK was hired by the facility on 11/6/23. The facility completed the following for CNA-KK: The BID was completed on 2/12/24. The DOJ was completed on 6/26/24. The IBIS was completed on 6/26/24 Surveyor noted the facility did not complete a BID, DOJ, and IBIS upon hiring CNA-KK. Activity Aide-LL was hired by the facility on 8/19/18. The facility completed the following for Activity Aide-LL: The BID was completed on 6/18/18. The DOJ was completed on 7/31/18. The IBIS was completed on 7/31/18. Surveyor noted the facility did not complete a BID, DOJ, and IBIS for Activity Aide-LL in the last 4 years. On 6/27/24 at 10:30 AM, Surveyor interviewed Human Resources (HR)-MM who has been in the position since July of 2023. HR-K states if an employee is hiredby the facility, a BID, DOJ, and IBIS is reviewed. HR-K states they are aware the BID, DOJ, and IBIS is to be completed every 4 years. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/1/24 at 10:00 AM, Surveyor shared concerns with NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B regarding the facility not completing a BID, DOJ, and IBIS every for CNA-KK upon hire. Surveyor shared concerns with NHA-A and DON-B regarding the facility not completing a BID, DOJ and IBIS for Activity Aide-LL in the last 4 years. Surveyor asked NHA-A how often a BID, DOJ, and IBIS should be completed for employees. NHA-A reported that a BID, DOJ, and IBIS should be completed every 4 years for employees. No additional information was provided as to why the facility did not properly complete a BID (Background Information Disclosure) form, DOJ (Department of Justice) form, and IBIS (Integrated Background Information System) form for 2 staff members.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48391 Based on interview and record review the facility did not ensure 2 (R499 and R118) of 3 abuse allegations reviewed were reported to the State Agency. * On 4/16/2024, R499 filed a grievance indicating she did not receive care. R499 alleged she did not receive cares overnight on 4/16/2024. The facility did not report this allegation to the State Agency. * On 6/9/24, R188 was found with his hand down R73's pants. The facility failed to submit the initial self-report within the 2-hour timeframe for an allegation of sexual abuse to the state agency and the police were not notified of this allegation of sexual abuse until the next day. Findings include: The facility's policy Abuse, Neglect and Exploitation dated as last revised on 1/5/24 documents: Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Definition: Abuse means the willful infliction of injury, unreasonable, confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The facility will develop and implement written policies and procedures that: 1. Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. 2. Establish policies and procedures to investigate any such allegations. Identification of Abuse, Neglect and Exploitation: 1. Failure to provide care needs such as feeding, bathing, dressing, turning and positioning. Investigation of Alleged Abuse, Neglect and Exploitation: 1. An immediate investigation is warranted when allegation or suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Reporting/Response: 1. The facility will have written procedures that include reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specified timeframes. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1.) R499 was admitted to the facility on [DATE]. R499's diagnoses include encephalopathy, chronic obstructive pulmonary disorder, chronic kidney disease, gout, and osteoarthritis. R499's Admission MDS (Minimum Data Set) completed on 4/24/24 documents that R499 is incontinent of urine and bowel and requires substantial/maximal assistance with toileting and bathing. R499 was also documented as having a BIMS (Brief Interview for Mental Status) score of 15, indicating that R499 is cognitively intact. R499's care plan, dated 4/15/24, documents: ~ R499 has actual impairment to the skin integrity right buttock, left buttock, right groin, left groin related to Moisture Associated Skin Damage (MASD). Date initiated 4/15/24. Interventions include: 1. Evaluate and treat per physicians orders. Date initiated 4/15/24. 2. Evaluate R499 for signs and symptoms of possible infections. Date initiated 4/15/24. 3. Apply barrier cream per facility protocol to help protect skin from excess moisture. Date initiated 4/29/24. 4. Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. Date initiated 4/29/24. 5. Educate R499/family/caregivers of causative factors and measures to prevent skin injury. Date initiated 4/29/24. 6. Follow facility protocols for treatment of injury. Date initiated 4/29/24. 7. Monitor/document location, size, and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration to Medical Director (MD). Date initiated 4/29/24. 8. Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. Date initiated 4/29/24. 9. Dietary consult as needed. Date initiated 4/23/24. 10. Encourage/assist with turning and reposition every 2-3 hours. Date initiated 4/23/24. 11. Monitor skin when providing cares, notify nurse of any changes in skin appearance. Date initiated 4/15/24. 12. Encourage good nutrition and hydration in order to promote healthier skin. Date initiated 4/23/24. ~ R499 has incontinence of bowel and bladder. Risk for skin breakdown and signs and symptoms of Urinary Tract Infections (UTI)s. Date initiated 4/15/24. Interventions include: 1. Provide skin care with each incontinent episode. Date initiated 4/16/24. 2. Clean peri-area with each incontinence episode. Date initiated 4/15/24. 3. Ensure R499 has the unobstructed path to the bathroom. Date initiated 4/23/24. 4. Monitor/document for signs and symptoms of UTI: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Date initiated 4/23/24. ~ R499 has potential for Activities of Daily Living (ADL) self-care performance deficit related to generalized weakness and hospitalization for toxic encephalopathy and diverticulosis. Date initiated 4/15/24. Interventions include: 1. Bathing assist of one. Date initiated 4/15/24. 2. Bed mobility with moderate assist of one. Date initiated 4/17/24. 3. R499 is independent with dining and prefers to eat in room. Date initiated 4/17/24. 4. Dressing requires set up for upper body and moderate assist of one for lower body dressing. Date initiated 4/17/24. 5. R499 is independent with toileting. Date initiated 4/17/24. 6. R499 requires physical assistance with transfers. Date initiated 4/16/24. 7. Encourage R499 to use bell to call for assistance. Date initiated 4/15/24. 8. Monitor/document/report as needed (PRN) any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function. Date initiated 4/15/24. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ R499 has limited physical mobility. Date initiated 4/15/24. Interventions include: 1. R499 uses a wheelchair. Date initiated 4/15/24. 2. Provide supportive care, assistance with mobility as needed. Date initiated 4/15/24. ~ R499 has nutritional problem or potential nutritional problem related to diet restrictions. Interventions include: 1. Obtain and document weights per MD orders and facility protocol. Date initiated 4/16/24. 2. Explain and reinforce to the resident the importance of maintaining the diet ordered. Encourage R499 to comply. Explain consequences of refusal such as obesity, malnutrition, or other risk factors. Date initiated 4/16/24. 3. Monitor/record/report to MD PRN signs and symptoms of malnutrition: Emaciation, muscle wasting, significant weight loss. Date initiated 4/16/24. 4. Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Date initiated 4/16/24. 5. Provide and serve diet as ordered. Date initiated 4/16/24. 6. Provide, serve diet as ordered. Monitor intake and record every meal. Date initiated 4/16/25. 7. Registered Dietician (RD) to evaluate and make diet change recommendations PRN. Date initiated 4/16/24. 8. Weigh at same time of day and record: monthly or as needed. Date initiated 4/16/24. ~ R499 can be resistive to medications and meals at times. Date initiated 4/23/24. Interventions include: 1. Allow the resident to make decisions about treatment regime, to provide sense of control. Date initiated 4/23/24. 2. Educate R499/family/caregivers of the possible outcome(s) of not complying with treatment or care. Date initiated 4/23/24. 3. Provide R499 with opportunities for choice during care provision. Date initiated 4/23/24. On 6/26/24 at 7:55 AM, Surveyor reviewed the facility grievance log which included a grievance that was filed for R499 on 4/17/24. The grievance for R499 indicated there were care concerns on the night of 4/16/24. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/24, at 1:26 AM, Surveyor interviewed Assistant Administrator-DD who stated she has been working with the facility for approximately 3 months and is new to the grievance process. Assistant Administrator-DD states she completes and investigates the grievances for the facility. Assistant Administrator-DD will receive grievances by staff, residents talking to her in person, or the grievance may be written on the grievance form and placed in the grievance box located outside her office. Surveyor asked Assistant Administrator-DD what the process is for grievances received. Assistant Administrator-DD states she will review the grievance and if she doesn't understand the grievance, she will go to the person filing the grievance for clarification. Assistant Administrator-DD states she will then talk with the resident listed on the grievance and start an investigation by talking with staff, nursing, unit manager, and reviews video cameras. Assistant Administrator-DD states she always keeps the manager of the department involved in the grievance informed. Assistant Administrator-DD states she received an anonymous grievance the morning of 4/17/24 for R499. The grievance stated R499 did not receive cares overnight on 4/16/24 and was not offered to be taken to the bathroom nor was she changed. Assistant Administrator-DD indicates she looked at the schedule to determine who worked R499's unit the night of 4/16/24. She then interviewed the Licensed Practical Nurse (LPN) and Certified Nursing Assistant (CNA) who was assigned to R499. Assistant Administrator-DD states she notified leadership and discussed the grievance in daily stand-up meetings. Assistant Administrator-DD reported she spoke with R499 on 4/22/24 to follow up on care concerns. Surveyor asked Assistant Administrator-DD why she didn't talk with R499 on 4/17/24, and Assistant Administrator-DD indicated she was new to the role and learning and that now starts with the residents as part of her investigation. Surveyor asked Assistant Administrator-DD if the care concern was reported to the state agency. Assistant Administrator-DD indicated the care concern was not reported to the state agency and notified Surveyor she is new and to the facility and the grievance process. On 7/1/24, at 8:14 AM, Surveyor interviewed DON- B who stated Assistant Administrator-DD is responsible for grievances within the facility. DON-B indicated she is notified of grievances within the facility and provided updates throughout the grievance process. DON-B stated she does not recall R499's grievance and care concerns filed on 4/16/24. DON-B stated she did not see a proper investigation into the care concern and was unaware if the allegation was reported to the state agency. Surveyor notified DON-B of concerns with the care concern not being reported to the state agency. Surveyor requested additional information if available. No additional information was provided as to why the facility did not report R499's care concern to the state agency. 20025 2.) Surveyor reviewed the facility's Abuse, Neglect and Exploitation policy dated 9/2020 with revised date of 1/5/24. The document indicates the following: . VII. Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes: a. Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Not later than 24 hours if the events that cause the allegation doe not involve abuse and do not result in serious bodily injury Surveyor reviewed facility self report regarding alleged sexual abuse. The investigation revealed that on 6/9/24 R188 was found with his hand down R73 pants. The NHA-A was made aware of the incident immediately. The initial self report was submitted on 6/10/24 at 1:35 p.m. to the state agency. The police were called for the allegation of sexual abuse on 6/10/24. On 6/27/24 at 9:58 a.m. Surveyor interviewed NHA-A regarding the reporting of the alleged sexual abuse. NHA-A stated she was made aware of the allegation on 6/9/24. DON-B called NHA-A to inform her of the allegation. NHA-A stated she was initially told R118 was found to be touching R73 inappropriately. NHA-A stated she was not aware of the details until 6/10/24 when she read Medication Technicians-R's statement dated 6/9/24. NHA-A stated that on 6/10/24, she made the initial reporting to the state agency and the police were called. On 7/1/24 at 11:30 a.m. Surveyor met with NHA-A and DON-B regarding concerns with R118. Surveyor expressed concern the initial facility self report was not submitted within the 2 hour timeframe for an allegation of sexual abuse and the police were not notified of this allegation of sexual abuse until the next day. No additional information was provided as to why the facility did not report the allegations of potential sexual abuse to the state agency within the required 2 hours timeframe.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 21855 Based on record review and interview, the facility did not document in a resident's medical record the reason for a transfer to the hospital for 1 (R124) of 9 resident hospital transfers from the facility that were reviewed. * R124 was transferred to the hospital on 3/3/24. There is no documentation in the medical record, of reason and location of what hospital R124 was transferred to. Findings include: The facility's policy Change in a Resident's Condition or Status, dated as revised 11/2015 documents: 7. The Nurse Supervisor/ Charge Nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status 1.) R124 progress note by (Licensed Practical Nurse) LPN-N on 3/3/24, at 11:35 PM, states Writer received a call from Officer-V regarding the resident's wear about. Writer was told that the resident was found safe at their sister's house, after the resident left the hospital on foot. the Officer-V also stated that the resident had caught 3 buses from the hospital to arrive at their sister house. The Officer-V stated that he will transport the resident back to the facility. There is not documentation in R124 medical record of the reason for going out to the hospital and the hospital visit itself. On 6/27/24, at 3:46 PM, during the facility exit meeting, Surveyor shared the concerns with R124 transfer with (Regional Nurse Consultant) RNC-D after R124 called 911 themselves. (Nursing Home Administrator) NHA-A and RNC-D stated they would look for additional information and let Surveyor know. On 7/01/24, at 9:13 AM, RNC-D and NHA-A, provided Surveyor with a facility incident report. This report states it is not part of the medical record and is private and confidential. The report documents R124 called 911, went to the hospital, and left the hospital on their own. The report does not indicate why 911 was called or what hospital. There was no documentation of R124 transfer to the hospital on 3/3/24. No additional information was provided as to why the facility did not document in R124's medical record the reason for a transfer to the hospital on 3/3/24.

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Bradley Estates Nursing and Rehab LLC	6735 W Bradley Rd Milwaukee, WI 53223

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21855 Based on record review and interview, the facility did not ensure residents received the required transfer notices, in writing, with a transfer from the facility. This was observed with 10 (R31, R47, R124, R106, R13, R15, R27, R64, R110 and R81) of 10 resident transfer's reviewed. * R31, R47, R124, R106, R13, R15, R27, R64, R110 and R81, were transferred from the facility to a hospital. There was no documentation in the medical record of receiving the notice requirements. Findings include: There is not a facility policy and procedure for the written transfer notice information. On 6/26/24, at 1:07 PM, Surveyor spoke with (Assistant Director of Nurses) ADON-C. ADON-C stated the written transfer notice information does not get sent with the resident transfer. The written transfer notices are part of the bed-hold form. That form is not sent with the resident. 1.) R31 medical record documents a hospital visit from 1/31/24 - 2/3/24. There is no information in the medical record they received the written transfer notice information. On 6/26/24, at 3:00 PM, during the daily exit meeting with (Nursing Home Administrator) NHA-A, (Director of Nurses) DON-B and (Regional Nurse Consultant) RNC-D. Surveyor requested any addition information for R31 hospital transfer. On 6/27/24, there was no additional information provided as to why R31 did not get a writer transfer notice when transferred to the hospital on 1/31/24. 2.) R47 medical record documents a hospital stay's on 12/29/23 - 1/4/24; 3/15/24 - 3/18/24; 4/5/24 - 4/9/24. There is no information in the medical record they received the written transfer information. On 6/26/24, at 3:00 PM, during the daily exit meeting with (Nursing Home Administrator) NHA-A, (Director of Nurses) DON-B and (Regional Nurse Consultant) RNC-D. Surveyor requested any addition information for R47 hospital transfer. On 6/27/24, there was no additional information provided as why R47 did not get a written transfer notice when transferred to the hospital on the above dates. 3.) R124 medical record documents a hospital visit from 9/14/23 - 9/17/23. There is no information in the medical record they received the written transfer information. On 6/26/24, at 3:00 PM, during the daily exit meeting with (Nursing Home Administrator) NHA-A, (Director of Nurses) DON-B and (Regional Nurse Consultant) RNC-D. Surveyor requested any addition information for R124 hospital transfer. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/27/24, there was no additional information provided as to why R124 did not get a written transfer notice on 9/14/23. 20025 4.) R106 nurses notes dated 6/22/24 documents R106 was sent to the hospital due to an unresponsive episode and seizure like activity. There is no evidence, in the medical record, of a transfer notice completed for R106. On 6/27/24 at 3:00 p.m. during the daily exit meeting with NHA-A and DON-B, Surveyor asked for the transfer notice for R106's transfer to the hospital on 6/22/24. As of 7/1/24 Surveyor did not receive any additional information regarding R106 transfer notice. 22692 5.) On 6/27/24 R81's medical record and it indicated R81 was transferred to the hospital on 10/23/23. R81's medical record did not include documentation that a transfer notice had been given to the resident and/or representative for the hospitalization . On 6/27/24 at 11:57 AM, Nursing Home Administrator (NHA)-A was interviewed and indicated a transfer notice was not completed for R81 on 10/27/23 and should have been. On 6/27/24 at 3:00 PM, the above findings were shared with NHA-A and Director of Nursing-B. Additional information was requested if available. No further information was provided as to why R81 was not given a transfer notice on 10/27/23 when he was transferred to the hospital. 38253 6.) R110 was admitted to the facility on [DATE] with diagnoses of prostate cancer and anemia. R110 had an activated Power of Attorney (POA). On 4/18/2024, R110 was sent to the hospital and admitted with a diagnosis of anemia. No documentation was found of a transfer notice for R110's hospitalization on [DATE] being provided to R110 or R110's POA. On 6/26/2024 at 3:03 PM at the daily exit with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B, Surveyor shared the concern no documentation of a transfer notice was found that was provided to R110 or R110's POA. Surveyor requested a copy of the transfer notice for R110's hospitalization on [DATE]. On 6/27/2024 at 7:30 AM, Surveyor was provided a folder with copies of documents that had been requested on 6/26/2024, but R110's transfer notice were not included in the copied documents. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/27/2024 at 3:46 PM at the daily exit with NHA-A and DON-B, Surveyor shared R110's transfer notice was not included in the documents received at the beginning of the day. NHA-A stated if the documentation was not in the folder provided at the beginning of the day from the information requested yesterday, then there is nothing in the resident record to provide. Surveyor verified with NHA-A that R110 did not have a transfer notice provided to R110 or R110's POA on 4/18/2024. NHA-A stated that was correct. No further information was provided at that time. 42037 7.) R13's medical record documents R13 was hospitalized on [DATE], 3/13/24 and 4/21/24. Surveyor reviewed R13's medical record. Surveyor could not identify documentation in R13's medical record R13 received the written transfer notice information for hospitalization s on 1/28/24, 3/13/24 or 4/21/24. On 6/26/24, at 3:00 PM, during the daily exit meeting with NHA-A, DON-B and RNC-D, Surveyor requested written transfer notice information for R13's hospitalization s on 1/28/24, 3/13/24 and 4/21/24. On 6/27/24 at 9:00 AM, Surveyor followed up with NHA-A regarding R13's written transfer notices for hospitalization s on 1/28/24, 3/13/24 and 4/21/24. No additional information was provided by the facility at this time. 8.) R15's medical record documents R15 was hospitalized on [DATE], 4/4/24 and 4/23/24. Surveyor reviewed R15's medical record. Surveyor could not identify documentation in R15's medical record R15 received the written transfer notice information for hospitalization s on 2/25/24, 4/4/24 and 4/23/24. On 6/26/24, at 3:00 PM, during the daily exit meeting with NHA-A, DON-B and RNC-D, Surveyor requested written transfer notice information for R15's hospitalization s on 2/25/24, 4/4/24 and 4/23/24. On 6/27/24 at 9:00 AM, Surveyor followed up with NHA-A regarding R15's written transfer notices for hospitalization s on 2/25/24, 4/4/24 and 4/23/24. No additional information was provided by the facility at this time. 47094 9.) R64 was admitted to the facility on [DATE] with diagnoses of repeated falls, anxiety disorder, vascular dementia, major depressive disorder, and cerebral infarction. R64 had an activated Power of Attorney (POA). On 3/20/2024, R64 was transferred and admitted to the hospital. On 3/27/2024, R64 was transferred and admitted to the hospital. Surveyor reviewed R64's medical record and could not find any documentation that a transfer notice had been given to R64 or R64's activated POA. On 6/26/2024, at 3:303 PM, Surveyors requested transfer notices for residents from the nursing home administrator (NHA)-A and Director of nursing (DON)-B. Surveyor requested to see transfer notice for R64's hospitalization s for 3/20/2024 and 3/27/2024. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/27/2024, at 3:46 PM, Surveyors requested transfer notices again for the residents. NHA-A and DON-B verified that they did not have transfer notices for the residents including R64's transfer to the hospital on 3/20/2024 and 3/27/2024. 10.) R27 was admitted to the facility on [DATE] with diagnoses of severe protein-calorie malnutrition, end stage renal disease with dependence on renal dialysis, anemia, mild cognitive impairment, and adult failure to thrive. R27 has a legal guardian. On 5/9/2024, R27 was transferred and admitted to the hospital. Surveyor reviewed R27's medical record and could not find any documentation that a transfer notice had been given to R27 or R27's legal guardian. On 6/26/2024, at 3:303 PM, Surveyors requested transfer notices for residents from the nursing home administrator (NHA)-A and Director of nursing (DON)-B. Surveyor requested to see transfer notice for R27's hospitalization s for 5/9/2024. On 6/27/2024, at 3:46 PM, Surveyors requested transfer notices again for the residents. NHA-A and DON-B verified that they did not have transfer notices for the residents including R27's transfer to the hospital on 5/9/2024.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21855 Based on record review and interview, the facility did not ensure residents received the required bed-hold information, in writing, with a transfer from the facility. This was observed with 10 (R31, R47, R124, R106, R13, R15, R27, R64, R110 and R81) of 10 resident transfer's reviewed. * R31, R47, R124, R106, R13, R15, R27, R64, R110 and R81, were transferred from the facility to a hospital. There was no documentation in the medical record of receiving the required bed-hold information. Findings include: The facility's policy and procedures for Bed-Hold and Return Guidelines, dated 4/25/29, documents: A. The facility will provide written information to the resident or resident representative before the resident is transferred to the hospital. On 6/26/24, at 1:07 PM, Surveyor spoke with (Assistant Director of Nurses) ADON-C. ADON-C stated the written Bed-Hold information notice does not get sent with the resident transfer. In morning report they will receive who was in the hospital. They then call, the resident/ representative, and provide the bed-hold information. The bed-hold information is not sent with the resident. 1.) R31 medical record documents a hospital visit from 1/31/24 - 2/3/24. There is no information in the medical record they received the written Bed-Hold notice. On 6/26/24, at 3:00 PM, during the daily exit meeting with (Nursing Home Administrator) NHA-A, (Director of Nurses) DON-B and (Regional Nurse Consultant) RNC-D. Surveyor requested any addition information for R31 bed-hold information. On 6/27/24, at 7:30 AM, NHA-A provided a Bed-Hold notice, dated 2/2/24, of verbal notification. There was no additional information provided. 2.) R47 medical record documents a hospital stay's on 12/29/23 - 1/4/24; 3/15/24 - 3/18/24; 4/5/24 - 4/9/24. There is no information in the medical record they received the written Bed-Hold notice. On 6/26/24, at 3:00 PM, during the daily exit meeting with (Nursing Home Administrator) NHA-A, (Director of Nurses) DON-B and (Regional Nurse Consultant) RNC-D. Surveyor requested any addition information for R47 bed-hold's. On 6/27/24, at 7:30 AM, NHA-A provided a Bed-Hold notice, dated 12/29/23, of a verbal consent for a bed-hold. There was no additional information provided for any other transfer dates. 3.) R124 medical record documents a hospital visit from 9/14/23 - 9/17/23. There is no information in the medical record they received a Bed-Hold notice. R124 did return to the same room in the facility. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/26/24, at 3:00 PM, during the daily exit meeting with (Nursing Home Administrator) NHA-A, (Director of Nurses) DON-B and (Regional Nurse Consultant) RNC-D. Surveyor requested any addition information for R124 bed-hold. On 6/27/24 there was no additional information provided on why R124 did not recieve a bed hold notice on 9/14/23. 20025 4.) On 6/22/24, R106 was sent to the hospital due to an unresponsive episode and seizure like activity. There is no evidence, in the medical record, of a bed hold notice completed for R106. On 6/27/24 at 3:00 p.m. during the daily exit meeting with NHA-A and DON-B, Surveyor asked for the bed hold policy for R106's transfer to the hospital on 6/22/24. As of 7/1/24 Surveyor did not receive any additional information regarding why R106 did not recieve a bed hold notice on 6/22/24 when he was transfered to the hospital. 22692 5.) R81's medical record was transferred to the hospital on 10/23/23. R81's medical record did not include documentation that a bed hold notice had been given to the resident and/or representative for the hospitalization . On 6/27/24 at 11:57 AM, Nursing Home Adminstrator (NHA)-A was interviewed and indicated a bed hold notice was not completed for R81 on 10/27/23 and should have been. On 6/27/24 at 3:00 PM, the above findings were shared with NHA-A and Director of Nursing-B. Additional information was requested if available. No further information was provided as to why R81 was not given a bed hold notice on 10/27/23 when he was transferred to the hospital. 38253 6.) R110 was admitted to the facility on [DATE] with diagnoses of prostate cancer and anemia. R110 had an activated Power of Attorney (POA). On 4/18/2024, R110 was sent to the hospital and admitted with a diagnosis of anemia. No documentation was found of a bed hold notice for R110's hospitalization on [DATE] being provided to R110 or R110's POA. On 6/26/2024 at 3:03 PM at the daily exit with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B, Surveyor shared the concern no documentation of a bed hold notice was found that was provided to R110 or R110's POA. Surveyor requested a copy of the bed hold notice for R110's hospitalization on [DATE]. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/27/2024 at 7:30 AM, Surveyor was provided a folder with copies of documents that had been requested on 6/26/2024, but R110's bed hold notice was not included in the copied documents. On 6/27/2024 at 3:46 PM at the daily exit with NHA-A and DON-B, Surveyor shared R110's bed hold notice was not included in the documents received at the beginning of the day. NHA-A stated if the documentation was not in the folder provided at the beginning of the day from the information requested yesterday, then there is nothing in the resident record to provide. Surveyor verified with NHA-A that R110 did not have a bed hold notice provided to R110 or R110's POA on 4/18/2024. NHA-A stated that was correct. No further information was provided at that time. 42037 7.) R13's medical record documents R13 was hospitalized on [DATE], 3/13/24 and 4/21/24. Surveyor reviewed R13's medical record. Surveyor could not identify documentation in R13's medical record for completed bed hold policy information for hospitalization s on 1/28/24, 3/13/24 or 4/21/24. On 6/26/24, at 3:00 PM, during the daily exit meeting with NHA-A, DON-B and RNC-D, Surveyor requested completed bed hold policy information for R13's hospitalization s on 1/28/24, 3/13/24 and 4/21/24. On 6/27/24 at 9:00 AM, Surveyor followed up with NHA-A regarding R13's completed bed hold policy information for hospitalization s on 1/28/24, 3/13/24 and 4/21/24. No additional information was provided by the facility at this time. 8.) R15's medical record documents R15 was hospitalized on [DATE], 4/4/24 and 4/23/24. Surveyor reviewed R15's medical record. Surveyor could not identify documentation in R15's medical record for completed bed hold policy information for R15's hospitalization s on 2/25/24, 4/4/24 and 4/23/24. On 6/26/24, at 3:00 PM, during the daily exit meeting with NHA-A, DON-B and RNC-D, Surveyor requested completed bed hold policy information for R15's hospitalization s on 2/25/24, 4/4/24 and 4/23/24. On 6/27/24 at 9:00 AM, Surveyor followed up with NHA-A regarding R15's completed bed hold policy information on 2/25/24, 4/4/24 and 4/23/24. No additional information was provided by the facility at this time. 47094 9.) R64 was admitted to the facility on [DATE] with diagnoses of repeated falls, anxiety disorder, vascular dementia, major depressive disorder, and cerebral infarction. R64 had an activated Power of Attorney (POA). On 3/20/2024, R64 was transferred and admitted to the hospital. On 3/27/2024, R64 was transferred and admitted to the hospital. Surveyor reviewed R64's medical record and could not find any documentation that a bed hold had been given to R64 or R64's activated POA on 3/20/24 or 3/27/24. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/26/2024, at 3:303 PM, Surveyors requested transfer notices for residents from the nursing home administrator (NHA)-A and Director of Nursing (DON)-B. Surveyor requested to see the bed holds for R64's hospitalization s for 3/20/2024 and 3/27/2024. On 6/27/2024, at 3:46 PM, Surveyors requested bed holds again for the residents. NHA-A and DON-B verified that they did not have transfer notices for the residents including R64's bed holds for R64's hospitalization s on 3/20/2024 and 3/27/2024. 10.) R27 was admitted to the facility on [DATE] with diagnoses of severe protein-calorie malnutrition, end stage renal disease with dependance on renal dialysis, anemia, mild cognitive impairment, and adult failure to thrive. R27 has a legal guardian. On 5/9/2024, R27 was transferred and admitted to the hospital. Surveyor reviewed R27's medical record and could not find any documentation that a bed hold had been given to R27 or R27's legal guardian. On 6/26/2024, at 3:303 PM, Surveyors requested bed holds for residents from the nursing home administrator (NHA)-A and Director of nursing (DON)-B. Surveyor requested to see the bed hold for R27's hospitalization for 5/9/2024. On 6/27/2024, at 3:46 PM, Surveyors requested bed holds again for the residents. NHA-A and DON-B verified that they did not have bed holds for the residents including R27's bed hold for R27's hospitalization on [DATE].

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on interview and record review, the facility did not ensure comprehensive care plans were implemented and included participation by the resident or resident representative for 2 (R102 & R124) of 32 resident care plans reviewed. *R102 did not have any documented care conferences since admission on 4/15/2023 and did not have a care plan developed that included R102's preferences. *R124 did not have any care conferences to discuss discharge planning and the care plan was not revised after elopement attempts or refusals to take antidepressant medication. Findings include: The facility policy and procedure entitled Care Management Guideline undated documents: Guideline: Care Management is implemented when a qualifying change in condition occurs which require skilled services, interdisciplinary (IDT) collaboration, and timely proactive communication beyond the standard practices of communication established in the facility. Care Management is conducted upon admission or readmission from an acute setting. The purpose of the Initial Care Management meeting is to communicate to the patient and patient representative, within 48 hours of admission, the baseline plan of care, barriers to the discharge plan, and care and services to be provided. The initial care management meeting is an important part of establishing a partnership with the patient and patient representative which in turn contributes to achieving transitional care goals. Ongoing Care Management Meetings allows the IDT to communicate regarding the patient's progress and to adjust the plan of care should the patient's clinical status and/or stated discharge plans change. The patient and patient representative will be informed of any changes to the plan of care established at the initial Care Management Meeting. Process: 1. Initial Care Management Meeting Scheduling -Meetings are scheduled in 20 minute increments at established times in the facility. The established times allow completion of the meeting within 48 hours of admission. -Admissions staff will explain the Care Management process to the patient and the patient representative and invite them to the Initial Care Management Meeting. Attendance may be either in person or by phone. -Initial Care Management Meetings scheduled for the day will be announced at the morning stand up. 2. Patient Evaluation -Prior to the Initial Care Management Meeting, IDT members complete an evaluation of the patient to identify: discharge plans, specific barriers to the discharge plan, and estimated length of stay. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-IDT members should collaborate on evaluation findings prior to the Initial Care Management meeting whenever possible. 3. Initial Care Management Meeting Guideline: -Attendees: MDS or Nurse Designee/Therapy/SS/Patient and Patient Representative -The MDS staff of nursing designee will facilitate the meeting . -MDS staff or nursing designee documents the meeting utilizing the Care Management Evaluation. -The Initial Care Management Evaluation/baseline plan of care will be printed and given to the Patient or Patient Representative. 4. Ongoing Care Management Meeting Guideline -MDS staff or Nurse Designee/Therapy/SS/BOM/other IDT members as needed -Ongoing Care Management Meetings occur until barriers are resolved and the transition to the discharge setting is complete. -Should the IDT conclude that the discharge plan is clinically inconsistent with the patient's likely functional outcome, a Care Conference is scheduled with the patient and patient representative to provide education, and modify plans for discharge and ongoing care. -MDS staff or nursing designee will document the meeting utilizing the Care Management Evaluation. The facility policy and procedure entitled Care Plan - Comprehensive from (C)2001 MED-PASS revised 10/2010 documents: Policy Interpretation and Implementation 1.Our facility's Care Planning/Interdisciplinary Team including the physician, Registered Nurse, nurse aide, member of food and nutrition services staff and/or other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident in coordination with the resident, his/her family or resident representative, develops and maintains a comprehensive persons-centered care plan consistent with resident rights for each resident that identifies the highest level of functioning the resident may be expected to attain. 2. The comprehensive care plan is based on a thorough assessment that includes strengths, goals, life history and preferences, but is not limited to, the MDS. 3. Each resident's comprehensive care plan after each assessment including both the comprehensive and quarterly review assessments is designed to: a. Incorporate identified problem areas and goals for desired outcomes; b. Incorporate risk factors associated with identified problems; c. Build on the resident's strengths; (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. Reflect the resident's expressed preferences, wishes regarding care and treatment goals including a desire to return to the community; e. Reflect treatment goals, timetables and objectives in measurable outcomes; f. Identify the professional services that are responsible for each element of care; g. Aid in preventing or reducing declines in the resident's functional status and/or functional levels; h. Enhance the optimal functioning of the resident by focusing on a rehabilitative program; and i. Reflect currently recognized standards of practice for problem areas and conditions. j. Coordinate: Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning and transitions of care. l. Discharge needs of each resident will be identified and result in the development of a discharge plan for each resident. m. Include regular re-evaluation of resident to identify changes that require modification of the discharge plan. The plan will be updated as needed to reflect changes. n. Will include referrals to local contact agencies or other appropriate entities made for this purpose and update accordingly. 4. Areas of concern that are triggered during the resident assessment are evaluated using specific assessment tools (including Care Area Assessments) before interventions are added to the care plan. 5. Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. When possible, interventions address the underlying source(s) of the problem area(s), rather than addressing only symptoms or triggers. It is recognized that care planning individual symptoms or Care Area Triggers in isolation mat have little, if any, benefit for the resident. 6. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident are interdisciplinary processes that require careful data gathering, proper sequencing of events and complex clinical decision making. No single discipline can manage the task in isolation. The resident's physician (or primary healthcare provider) is integral to this process. 7. The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (MDS). 8. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. (continued on next page)

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	525325	A. Building B. Wing	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bradley Estates Nursing and Rehab LLC	6735 W Bradley Rd Milwaukee, WI 53223

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans; a. When there has been a significant change in the resident's condition; b. When the desired outcome is not met; c. When the resident has been readmitted to the facility from a hospital stay; and d. At least quarterly. 10. The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. When such refusals are made, appropriate documentation will be entered into the resident's clinical records in accordance with established policies. 1.) R102 was admitted to the facility on [DATE] with diagnoses of anxiety, depression, diabetes, delusional disorders, acquired hemophilia, chronic obstructive pulmonary disease, and atrial fibrillation. R102 did not have an activated Power of Attorney. On 6/25/2024 at 10:30 AM, Surveyor asked R102 if R102 had care conferences to discuss their plan of care and treatment. R102 stated they have never had any meetings to discuss care or discharge goals. R102 stated R102 had been asking since admission to see a psychologist but has not seen one. No documentation was found of care conferences being conducted for R102 since admission. On 6/26/2024 at 3:03 PM, at the daily exit, Surveyor informed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B of the concern that there was no documentation of care conferences for R102. Surveyor requested a copy of any documentation showing R102 has had any care conferences since admission. On 6/27/2024 at 7:30 AM, Surveyor was provided a folder with copies of documents that had been requested on 6/26/2024. Surveyor noted the facility provided a copy of a progress note Social Worker (SW)-P. The progress note was dated 6/26/2024 at 4:44 PM, after Surveyor had brought the concern of no documentation of care conferences to the facility's attention. The progress note documented SW-P had met with R102 on 5/8/2024 to discuss R102's current plan of care, any concerns that R102 may have and to discuss R102's current discharge plans. R102's health was stable and there were no new updates at that time. R102 did not have any concerns at that time. R102 wished to remain in the facility for long-term care. On 6/27/2024 at 3:46 PM, at the daily exit with NHA-A and DON-B, Surveyor verified that a progress note by SW-P had been written the previous day about a care conference discussion on 5/8/2024 and asked if R102 had any other documentation of attending a care conference. NHA-A stated R102 would be able to tell Surveyor about care conferences. Surveyor shared with NHA-A and DON-B that R102 brought the lack of care conferences to Surveyor's attention and that was why Surveyor was asking for documentation of care conferences. NHA-A stated no other documentation was found for R102 care conferences. NHA-A stated NHA-A was sure care conferences were held and should have been held quarterly, but those conferences must not have been documented as they should have. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/1/2024 at 9:17 AM, Surveyor asked SW-P if SW-P was involved with R102's Care Conferences and if R102 had told Surveyor R102 requested to see a psychologist. SW-P stated no documentation was made of Care Conferences for R102. SW-P stated R102 sees a Psych Nurse Practitioner monthly or every other month for medication management. No additional information was provided at that time. 21855 2.) R124 was admitted on [DATE] due to a stroke. R124 (Power of Attorney for Healthcare) POA-HC was activated prior to admission. R124's Admission (minimum data set) MDS assessment completed on 5/22/23, indicates no wandering behavior with moderate cognitive impairment. R124 had verbalized they wanted to go home. R124 was moved to a alarmed unit on 12/1/24 due to R124 walking towards the sidewalk and away from the facility. On 3/3/24, R124 eloped from the hospital to her sister's house. There was no changes in the plan of care at that time of this elopement. On 5/14/24 the facility applied a wanderguard with no wandering/elopement assessment completed. The wanderguard was added as intervention however, there is not a plan of care for this device. R124 has been prescribed antidepressant medication. R124 does not want to take the medication. R124 isolates in their room and wants to go home. R124 progressed in cognition during their stay at the facility. R124 Annual MDS assessment, completed 3/20/24, shows no wandering behavior and no cognitive impairment. R124 requires set-up for activity of daily living and performs the tasks themselves. On 6/23/24 R124 verbalized they were being picked up and wanted to leave. The facility staff re-directed R124 back to their room. R124 then tied bed linens together and exited out their room window. R124 received bilateral ankle fracture requiring surgical intervention. There is not documentation of any care plan conferences with the resident, POA-HC and other disciplinary staff, to discuss R124 plan of care needs. This includes R124 verbalizations to be discharged , medication alternatives and cognitive status. On 6/27/24, at 1:58 PM, Surveyor spoke with (Social Worker) SW-P. SW-P stated they moved R124 upstairs to the alarmed unit. R124 was packing their bags, and verbalized, leaving the facility. SW-P stated R124 liked upstairs because it was more quite. R124 family would take them out for visits. R124 voiced they wanted to go home. The family was trying to work something out to bring R124 home. R124 was refusing their antidepressant medication. R124 stated they were not depressed and did not want medication. SW-P stated all staff do care planning. SW-P indicated they had talked to the POA-HC about discharge planning. SW-P has been waiting for the family to decide on discharge placement. R124 has a social service note, on 2/5/24, that states the POA-HC was called, message left, to discuss discharge planning. There was no additional documentation regarding discharge planning. R124 has a social service note, on 3/12/24, that states the POA-HC was called to schedule a care conference. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/27/24, at 3:46 PM, during the facility exit meeting, Surveyor shared concerns with (Nursing Home Administrator) NHA-A. R124 does not have documentation of care planning for elopements with desire to discharge home. On 7/01/24, at 9:06 AM, SW-P spoke with Surveyor. SW-P provided a care conference meeting form, dated 10/11/23, as a quarterly review. There was no other care plan conference's provided. On 7/01/24, 1:45 PM, Surveyor spoke with (Nurse Practitioner) NP-Q. NP-Q sees R124 weekly for psychiatric management. R124 does not feel they are depressed. They do want to take an antidepressant. They just want to go home. NP-Q stated they have not been asked to attend any care plan conferences or do any other assessments. No additional information was provided.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48391 Based on interview and record review the facility did not ensure 1 (R499) of 32 residents reviewed based on the comprehensive assessment of a resident, residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. R499 developed Moisture Associated Skin Disorder (MASD) while residing in the facility. The facility did not perform skin checks throughout R499's stay from 4/15/24 through 5/3/24. Findings include: The facility's policy Skin Management Guideline dated 11/28/17 documents: Purpose: To ensure residents that are admitted to the facility are evaluated to determine appropriate measures to be taken by the interdisciplinary care team to determine appropriate measures and individualized interventions to prevent, reduce and treat skin breakdown. Monitoring of Skin Integrity: Weekly skin observation on the bath/shower day will be performed by a Licensed Nurse. If a skin concern is noted, refer to the skin and wound care formulary. Resident Choice: In order for a resident to exercise his or her right to appropriately make informed choices about care and treatment or to refuse treatment, the facility and the resident (or the Resident Representative) will discuss the resident's condition, treatment options, expected outcomes, and consequences of refusing treatment. The facility will address the resident's concerns and offer relevant alternatives if the resident has refused treatments/interventions. This will be documented in Point Click Care (PCC) using the risk versus benefits to provide an opportunity to make an informed decision. R499 was admitted to the facility on [DATE]. R499's diagnoses include encephalopathy, chronic obstructive pulmonary disorder, chronic kidney disease, gout, and osteoarthritis. R499's Admission MDS (Minimum Data Set) completed on 4/24/24 documents that R499 is incontinent of urine and bowel and requires substantial/maximal assistance with toileting and bathing. R499 was documented as having a BIMS (Brief Interview for Mental Status) score of 15, indicating that R499 is cognitively intact. R499's care plan, dated 4/15/24, documents: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ R499 has actual impairment to the skin integrity right buttock, left buttock, right groin, left groin related to Moisture Associated Skin Damage (MASD). Date initiated 4/15/24. Interventions include: 1. Evaluate and treat per physicians orders. Date initiated 4/15/24. 2. Evaluate R499 for signs and symptoms of possible infections. Date initiated 4/15/24. 3. Apply barrier cream per facility protocol to help protect skin from excess moisture. Date initiated 4/29/24. 4. Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. Date initiated 4/29/24. 5. Educate R499/family/caregivers of causative factors and measures to prevent skin injury. Date initiated 4/29/24. 6. Follow facility protocols for treatment of injury. Date initiated 4/29/24. 7. Monitor/document location, size, and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration to Medical Director (MD). Date initiated 4/29/24. 8. Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. Date initiated 4/29/24. 9. Dietary consult as needed. Date initiated 4/23/24. 10. Encourage/assist with turning and reposition every 2-3 hours. Date initiated 4/23/24. 11. Monitor skin when providing cares, notify nurse of any changes in skin appearance. Date initiated 4/15/24. 12. Encourage good nutrition and hydration in order to promote healthier skin. Date initiated 4/23/24. ~ R499 has incontinence of bowel and bladder. Risk for skin breakdown and signs and symptoms of Urinary Tract Infections (UTI)s. Date initiated 4/15/24. Interventions include: 1. Provide skin care with each incontinent episode. Date initiated 4/16/24. 2. Clean peri-area with each incontinence episode. Date initiated 4/15/24. 3. Ensure R499 has the unobstructed path to the bathroom. Date initiated 4/23/24. 4. Monitor/document for signs and symptoms of UTI: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Date initiated 4/23/24. ~ R499 has potential for Activities of Daily Living (ADL) self-care performance deficit related to generalized weakness and hospitalization for toxic encephalopathy and diverticulosis. Date initiated 4/15/24. Interventions include: 1. Bathing assist of one. Date initiated 4/15/24. 2. Bed mobility with moderate assist of one. Date initiated 4/17/24. 3. R499 is independent with dining and prefers to eat in room. Date initiated 4/17/24. 4. Dressing requires set up for upper body and moderate assist of one for lower body dressing. Date initiated 4/17/24. 5. R499 is independent with toileting. Date initiated 4/17/24. 6. R499 requires physical assistance with transfers. Date initiated 4/16/24. 7. Encourage R499 to use bell to call for assistance. Date initiated 4/15/24. 8. Monitor/document/report as needed (PRN) any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function. Date initiated 4/15/24. ~ R499 has limited physical mobility. Date initiated 4/15/24. Interventions include: 1. R499 uses a wheelchair. Date initiated 4/15/24. 2. Provide supportive care, assistance with mobility as needed. Date initiated 4/15/24. On 6/26/24, at 7:55 AM, Surveyor reviewed R499's Treatment Administration Record (TAR) and noted an order being placed on 4/15/24, for R499 to have weekly skin checks. Surveyor notes there is no entry on 4/20/24 for her weekly skin check and a check mark on 4/27/24. Surveyor requested from the facility, documentation of weekly skin checks for R499. Surveyor reviewed R499's skin and bath report dated 4/27/24 which documents R499 refused her shower/bed bath and 3 attempts were made by staff. Surveyor noted a signature by the Certified Nursing Assistant (CNA) and that the nurse signature line and management designee review signature lines were both blank with no signatures. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/27/24, at 9:20 AM, Surveyor interviewed Wound Registered Nurse (RN)- Y who indicated the wound care team typically is notified by staff verbally with any skin changes that are identified staff with residents residing within the facility. Wound RN- Y stated the wound care team was notified of R499 having skin changes but was unable to identify what day and how the wound care team was notified of R499's skin changes. Wound RN- Y stated wound care was performed on R499 on 4/29/24, and R499 was noted to have facility acquired MASD. Wound RN- Y stated R499's care plan was updated to include interventions. Surveyor asked Wound RN- Y why R499's care plan was dated 4/15/24 with facility acquired MASD. Wound RN- Y indicated he made changes to R499's original care plan and did not delete the original care plan causing a discrepancy in dates. Surveyor informed Wound RN- Y that there was documentation of R499 having buttocks pain on 4/27/24 and excoriation in perineum, on 4/28/24. Surveyor asked why there was a delay with wound care seeing R499. Wound RN- Y states he is unsure how and when wound care team was notified of R499's skin care changes and stated R499 was evaluated and treated on 4/29/24 by wound care. On 7/1/24, at 8:14 AM, Surveyor interviewed Director of Nursing (DON)- B who stated she does not recall R499. Surveyor asked DON- B to explain what 3 attempts made on R499's 4/27/24 bath report. DON- B indicates 3 attempts were made on the PM shift on 4/27/24 to bathe R499, and R499 declined 3 times on the PM shift. DON- B indicated there were no further skin checks or bath attempts made throughout R499's stay at the facility from 4/15/24 through 5/3/24. Surveyor notified DON- B of the above findings with R499 developing facility acquired MASD and no skin checks or baths throughout R499's stay at the facility. Surveyor requested additional information if available. No additional information on R499 was provided as to the comprehensive assessment of a resident, residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21855 Based on record review and interviews, the facility did not comprehensively provide medically related social services, to attain the highest psychosocial well-being, of a resident for 1 (R124) of 30 residents reviewed. *R124 verbalized, and attempted, to leave the facility to go home. The facility did not look at whether R124 still needed activation of power of attorney for health care and could, thus make own health decisions, did not look at alternatives to Sertraline, an antidepressant that R124 refused to take, did not look at discharge alternatives, and did not develop a plan of care for supervising R124 when agitated and expressing a desire to leave. On 6/23/24 R124 verbalized a desire to leave the facility and kept setting off alarms on the unit trying to leave, R124 was not permitted to do so. R124 then utilized their bed sheets to climb out a second-story window. This resulted in R124 falling and fracturing both of their ankles and a leg. The facility failure to provide comprehensive social services created a finding of immediate jeopardy that began on 6/23/24. Surveyor notified (Nursing Home Administrator) NHA-A of the immediate jeopardy on 7/1/24 at 1:33 PM. The facility removed the immediate jeopardy on 7/12/24. The deficient practice continues at an E (potential for harm pattern) as the facility implements their action plan. Findings include: Reassessment of need for Power of attorney R124 is a [AGE] year that was admitted on [DATE] due to a stroke. R124 has diagnoses of anxiety and depression. R124's POA-HC (Power of Attorney for Healthcare) was activated 3/30/23. R124's POA-HC was activated in a hospital setting due to delirium. R124 does not have a diagnosis of dementia or indications of ongoing delirium. R124's Admission MDS (minimum data set) assessment was completed on 5/22/23. The BIMS (Brief Interview for Mental Status) shows moderate cognitive impairment. R124's Annual MDS assessment was completed on 3/20/24. The BIMS shows no cognitive impairment. R124 requires set-up assist for activities of daily living. R124 is able to perform their own tasks. R124 had a BIMS (brief interview of mental status) completed on 6/20/24. This assessment documents no cognitive impairment. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Despite assessments showing no cognitive impairment, the facility did not reassess R124 to determine if the power of attorney should or could be deactivated and if R124 could be allowed to make their own health care decisions. On 7/01/24, at 01:45 PM, Surveyor spoke with (Nurse Practitioner) NP-Q. NP-Q stated they were not asked about deactivating the POA-HC status. On 6/26/24, at 11:21 AM, Surveyor spoke with (Social Worker) SW-P. SW-P stated they did not discuss any POA-HC de-activations. SW-P shared R124 did not ask for de-activation. Reassessment of antidepressant R124's Psychiatric Progress Note documents the following: - 3/12/24 (R124) is tolerating taking Sertraline 100 mg every day. This provider called and spoke with the POA-HC, to discuss medication changes, due to increased agitation. The POA-HC did not want to start or change any medication at this time. The POA-HC stated (R124) is upset because they want to come home. and needs to stay on the antidepressant. The POA-HC stated (R124) has had depression their whole life. -3/18/24 (R124's) Sertraline was increased to 125 mg every day for depression. This provider received a phone call from the POA-HC to discuss medications. The POA-HC felt (R124's) antidepressant could be increased due to (R124) feeling down. - 4/2/24 (R124) stated Does not want to take the antidepressant and does not think they need it. No change in Treatment Plan. - 4/9/24 4/17/24 (R124) stated Does not want to take the antidepressant and does not think they need it. No change in Treatment Plan. - 4/17/24 (R124) stated Does not want to take the antidepressant and does not think they need it. No change in Treatment Plan. -4/23/24 (R124) stated does not want to take the antidepressant and does not think they need it. The Treatment Plan (sic) this provider called the POA-HC about refusing the medication and throwing the pill out. (R124) isolates in their room with the lights out. The POA-HC stated they will talk with (R124). - 4/30/24 R124 stated does not want to take the antidepressant and does not think they need it. The Treatment Plan (sic) this provider called the POA-HC last week. They discussed (R124) refusing to take the antidepressant and throws the pill out. (R124) keeps isolating in their room and keeps the lights out. Discussed with facility staff to monitor (R124) taking their pills. The POA-HC stated they would talk with (R124). - 5/7/24 (R124) stated does not want to take the antidepressant, does not need it and takes the antidepressant and throws it away. The Treatment Plan (sic) 2 weeks this provider spoke with the POA-HC. They discussed (R124) refusing medication most days and throwing it out. They talked about (R124) isolating in their room. The POA-HC will talk with (R124). The facility staff will monitor (R124) taking their medications. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-5/14/24 (R124) stated does not want the antidepressant, does not need it' and takes the antidepressant and throws it away. The Treatment Plan (sic) discussed with facility staff to monitor (R124) taking medications. - 5/21/24 (R124) stated does not want to take the antidepressant, does not need it and takes the antidepressant and throws it away. The Treatment Plan (sic) facility staff to monitor (R124) taking their medications. - 5/29/24 (R124) stated does not want to take the antidepressant, does not need it and takes the antidepressant and throws it away. The Treatment Plan (sic) facility staff to monitor (R124) taking their medications. - 6/4/24 (R124) stated does not want to take the antidepressant, does not need it and takes the antidepressant and throws it away. The Treatment Plan (sic) facility staff to monitor R124 taking their medications. - 6/18/24 (R124) stated does not want to take the antidepressant, does not need it and takes the antidepressant and throws it away. The Treatment Plan (sic) facility staff to monitor R124 taking their medications. On 6/27/24, at 1:47 PM, Surveyor spoke with (Regional Nurse Consultant) RNC-O. RNC-O has overseen R124's unit the last few weeks. RNC-O stated R124 refused the Sertraline because they were not depressed. R124 stated they feel better and do not want the medication. RNC-O stated NP-Q comes in weekly. On 7/01/24, at 01:45 PM, Surveyor spoke with (nurse Practitioner) NP-Q, who took over R124's psych visits March 1st, at which time R124 was already on Sertraline 100 mg for a history of depression NP-Q stated R124 did not want to take the antidepressant and denied any anxiety or depression. R124 did mention they wanted to go home. NP-Q shared, a resident wanting to go home is a very common statement. NP-Q did talk with the POA-HC about going home. The POA-HC could not care for R124 at home. NP-Q did not do a cognitive or a living assessment. NP-Q was not involved in any Care Conferences to discuss R124's plan of care. NP-Q stated that R124 did not have suicidal thoughts or self-harm behaviors. R124 denied any negative behaviors. There was no collaboration to offer alternatives to antidepressant medication. Discharge planning R124 had 1 Care Conference on 10/11/23 for a Quarterly review. This included (Social Worker) SW-P and R124's POA-HC. The section for Discharge Plan states the resident will be long term care until an alternative and safe environment can be planned. There is no evidence the facility followed through on establishing an actual discharge plan and sought out an alternative and safe environment for R124 to discharge to. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bradley Estates Nursing and Rehab LLC	6735 W Bradley Rd Milwaukee, WI 53223

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R124 has a Social Worker note on 2/2/24 that states Family members wanted to take the resident home for the evening, but were unable to reach the POA-HC. They were not able to reach the POA-HC. The family was asking questions regarding POA-HC and how to get a new one. The Writer informed them the POA-HC is a legal document and they couldn't do anything. There is no evidence R124's cognitive status was reassessed to assist in establishing an individualized discharge plan. R124 was not in protective placement nor did R124 have a Guardianship. R124 wanted to go home and was not permitted to do so. R124 has a Social Worker note on 2/5/24 that states Writer left a message with the POA-HC to discuss discharge planning. There was no documented discharge planning process. R124 has a Social Worker note on 3/12/24 that states Writer called POA-HC to schedule a care plan conference. On 7/01/24, at 9:06 AM, Surveyor spoke with SW-P. SW-P stated the only care plan conference that was completed was on 10/11/23. Surveyor noted the only individuals present at that conference were SW-P and POA-HC. R124 was not included. On 6/26/24, at 11:21 AM, Surveyor spoke with SW-P about R124's typical day in the facility. SW-P stated R124 would just walk around the unit, and would try to leave, to go home. R124 was aware their daughter placed them here. R124 wanted to leave the facility to go home. There was discharge planning discussed with another family member. The POA-HC stated that family member was not home to supervise resident. They did not discuss any alternative placements for R124. R124's POA-HC was working on taking R124 home and has not secured that yet. When discussing the level of supervision provided to R124, SW-P shared R124 has never been on 1:1 (one on one) supervision at the facility. R124 will try to leave to go home and is easily redirected. SW-P stated R124 was determined to leave and go home. R124 was frustrated with their family taking so long to decide. On 7/01/24, at 9:13 AM, (Regional Nurse Consultant) (RNC)-D and (Nursing Home Administrator) NHA-A spoke to Surveyor. They shared R124's POA-HC did not have the ability to take R124 home. RNC-D and NHA-A stated R124 would not be safe to discharge on their own. R124 agreed to stay at the facility and liked their room upstairs. RNC-D is aware R124 does not take their antidepressant and has a history of depression. R124 wants to go home but is content with staying at the facility. There was no collaboration to offer alternatives to antidepressant medication, discharge planning, and cognitive status. Elopement risk R124's Wander/Elopement Risk Evaluations document the following: - Admission on 5/15/23, states there is no elopement history. There is no risk for elopement. - Quarterly on 8/17/23, states there is no elopement history. There is a risk to wander/elope. There are no behaviors triggered. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Re-Admission on 9/17/23, states there is no elopement history. There is no risk to wander/elopement. On 7/01/24, at 9:13 AM, RNC-D and NHA-A spoke to Surveyor. RNC-D stated that on 12/1/23 R124 was sitting outside the facility waiting for the POA-HC to pick them up. R124 decided to start walking from sitting outside. The facility treated it as an elopement just to be safe. They talked to R124 and the POA-HC to move R124 upstairs on the alarmed unit. This unit was also the dementia unit. R124's Wander/Elopement Risk Evaluations document the following: - (Untitled) on 12/4/23, states there is now a wander/elopement. (R124) does not accept placement, paces, attempt to exit facility, trying to find family and makes repetitive statements about going home. The Wander/Elopement Risk Care Plan added a secured unit and staff aware of wander risks. On 6/27/24, at 01:58 PM, Surveyor spoke with SW-P regarding R124's room change to a secured unit. SW-P stated R124 would pack their bags and voiced they wanted to leave. R124 agreed to move to the secured unit upstairs. The upstairs unit was quieter. R124's family would take them home to visit. R124 wanted to go home. R124 did not want to take any medication for depression. R124 would become anxious/ obsessive about leaving the facility. There is a phone for the residents to use on the unit. R124's POA-HC would be called at times to assist with redirection. SW-P shared R124 wanted to be alone even when they were on a different unit; R124 would sit by themselves. They were working with the POA-HC on going back home. R124's Wander/Elopement Risk Evaluations document the following: - Quarterly on 1/5/24, states is a wander/elopement history and risk. (R124) does not accept placement, paces, attempt to exit facility, trying to find family and makes repetitive statements about going home. The Wander/Elopement Risk Care Plan remains a secured unit, staff aware of wander risks. - Quarterly on 4/6/24, states is a wander/elopement history and risk. (R124) does not accept placement, paces, attempt to exit facility, trying to find family and makes repetitive statements about going home. The Wander/Elopement Risk Care Plan remains a secured unit, staff aware of wander risks. R124's plan of care states the resident is an elopement risk/wanderer with altered mental status. Date Initiated 08/17/2023, with a goal: resident's safety will be maintained through the review date of 9/15/2024. Interventions added: - Secured unit dated 12/04/2023. -Staff aware of resident's wander risk dated 8/17/2023. - WANDER ALERT Personal Safety Device: Right ankle dated 5/16/2024. R124's plan of care states - The resident wishes to return to the community. Date initiated 8/14/23, with a goal: the resident will verbalize an understanding of the discharge plan and describe the desired outcome, by the review date of 9/15/24. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interventions added: - Resident discharging home with community services dated 8/14/2023. R124's plan of care states - Supervise resident with administration of medications. Date initiated 5/2024, with a goal the resident will take medications safely and as prescribed, by the review date of 9/15/2024. Interventions added: - Discuss medications with each supervised administration dated 5/2/2024. - Encourage resident to take meds prescribed. May not want to take certain medications dated 5/2/2024. - Supervise resident taking their medications dated 5/2/2024. - update MD (Medical Doctor) with refusals dated 5/2/2024. On 6/27/24, at 1:47 PM, (Regional Nurse Consultant) RNC-O stated R124 was moved to the alarmed unit on 12/1/2024. This was because R124 was outside, and the upstairs is more secured. When asked about the creation of R124's care plans RNC-O stated there is not a designated staff that completes the resident plans of care. RNC-O stated the facility did complete a Facility Reported Incident for the 12/1/2023 occurrence. R124's Psychiatric Progress Notes document the following: -3/6/24 (R124) called 911, went to the hospital, and eloped from the hospital to their sister's house. (R124) has been more agitated and disoriented. (R124) has had verbal outbursts. (R124) continues on Sertraline 100 mg every day and tolerating well. This provider left a voice message for the POA-HC to discuss medication changes due to increased agitation. (Per R124's progress note by (Licensed Practical Nurse) LPN-N on 3/3/2024, at 11:35 PM Writer received a call from (Officer-V) regarding the resident's wear (sic) about. Writer was told that the resident was found safe at their sister's house, after the resident left the hospital on foot. (Officer-V) also stated that the resident had caught 3 buses from the hospital to arrive at her sister house. The (Officer-V) stated that he will transport the resident back to the facility.) R124's progress note by LPN-M states on 3/8/24, at 7:54 PM Resident noted wandering and trying to open exit doors. Redirected resident to their room. On 7/01/24, at 9:13 AM, RNC-D and NHA-A spoke to Surveyor. RNC-D and stated R124 left from the hospital and not the facility on 3/3/24. There is no additional documentation of an assessment or root cause about what happened to R124 on 3/3/24 and what services were provided to R124 upon their return to the facility. There is no individualized plan of care that identifies triggers, and appropriate interventions, to address R124's desire to leave the facility and live elsewhere. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/14/2024, at 9:32 PM R124's progress note by (Registered Nurse) RN-U states Resident did not try to leave unit all evening. Ate supper in their room. Writer placed a wander guard to resident's right ankle per order and resident did not refuse the placement. The wander guard was added to the plan of care as an intervention. There is not a correlating comprehensive assessment to determine the reason for this intervention/change in the plan of care. On 6/26/24, at 11:10 AM, Surveyor spoke with LPN-K. LPN-K is familiar with R124. LPN-K stated the wander guard was placed on R124 in May 2024 as a precaution. R124 had returned from a visit with the family and was agitated. R124 only attempted to leave through the alarmed doors and was easy to redirect. On 6/9/2024, at 10:23 PM R124's progress note by LPN-T states, At approximately 5:00 PM writer was in hallways and observed several Paramedics on unit. This writer was informed (R124) called 911 and stated they was (sic) having chest pain. (R124's) vital signs was (sic) taken and they were stable. This writer was informed resident would be transported to Hospital for Evaluation. POA-HC was informed and stated, this is not the first she done this (sic), am (sic) going to call this hospital to make sure they watch (R124). (R124) will escape. The facility did not send an escort to the hospital with R124. Surveyor noted R124 previously called 911 on 3/3/24 and left the hospital. R124 shows the cognitive ability to circumvent the alarmed doors on the unit by seeking 911 attention. This was demonstrated on 3/3/24 as well. On 6/26/24, at 11:30 AM, Surveyor spoke with Certified Nursing Assistant (CNA)-L. CNA-L worked the Day shift on 6/23/24. CNA-L stated the unit alarm was beeping towards the end of their shift. R124 stated someone was picking them up. CNA-L shared R124's family would sometimes take them out. R124 was always redirected when the doors alarms went off. R124 did not ever get to the elevators. CNA-L shared R124 preferred to stay in their room including eating in their room. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/23/24, at 11:49 PM R124's progress note by (Licensed Practical Nurse) LPN-E documents beginning of shift (R124) was anxious but easily redirected by PM staff. (R124) did not display further anxious behavior. (R124) was in good spirits for a while but (R124) did get upset later because (R124's) daughter wasn't answering the phone when (R124) was calling their daughter but (R124) didn't display any abnormal behaviors from that. (R124) tolerated meds well and ate 100% supper and (R124) was compliant with staff with directives. During the evening at approximately 2015 (8:15 pm) the two (Certified Nursing Assistants) CNAs came to writer while writer on the hall passing meds and asked writer would writer speak with (R124) regarding refusal to allow them to put bed linen on the bed. Writer approached (R124) and writer asked (R124) did (R124) refuse linen on their bed to the CNAs. (R124) stated No I didn't refuse, I do want linen on my bed. Staff then put linen on (R124's) bed after writer spoke with (R124). (R124) still showed no further behavior. CNAs put (R124's) roommate in bed then when CNAs were done (R124) was noticed by CNA assisting on their bed. Writer continued to pass meds Writer finished med pass at 2030 (8:30 pm) and came to check with med tech regarding a resident's issue on unit 600 When writer was checking on another resident's medication that is when writer was notified that (R124) had climbed out window and was outside sitting on buttocks talking to other staff that found (R124) outside on ground. Writer and the 2 CNAs inside building noticed (R124) had took (sic) the window out the frame (sic) and tied sheets together in knots and tied the sheets to the bed and climbed out the window with the sheets hanging out the window in knots. (R124) was being assessed immediately by the staff that were nurses outside. Writer then came out to further assess. Ambulance called and present and assessed (R124) head to toe. (R124) c/o (complained of) right lower leg pain to writer and ambulance. Daughter notified and aware of above findings Director of Nurses (DON-B) notified and (NHA-A) notified of above findings (Nurse Practitioner) NP notified and updated NP and daughter aware of resident going to hospital for further evaluation. On 6/27/24, at 11:42 AM, Surveyor spoke with CNA-J who worked the shift R124 exited through the window. CNA-J stated R124 made knots tying the sheets together. CNA-J is not sure where they got the bed sheets from. R124 was setting off the unit door alarms wanting to go home during the shift. They were redirected back to their room. CNA-J shared R124 typically does not come out of their room. After supper they had no linen on their bed. R124 did not want their bed made. CNA-J told the floor nurse R124 did not want their bed made. Then R124 stated they could make their own bed. R124 was provided bed sheets. There were pictures obtained of the bed sheets out the window. There were bed sheets on the bed. CNA-J thought R124 did not show any different behavior before the discovery outside. On 6/27/24, at 12:58 PM, Surveyor spoke with CNA-I who worked the evening shift on 6/23/24. CNA-I stated R124 was dressed, with their jacket on, trying to go out the unit door. R124 stated they wanted to go home. R124's family was not answering the phone. R124 was getting frustrated about not getting a hold of their daughter. CNA-I stated around 7:30 - 8:00 PM they were assisting R124's roommate to bed. They noticed R124 had no sheets on their bed. They offered to make their bed and she said no. They told the floor nurse about the sheets. The nurse talked to R124 about the bed sheets. CNA-I brought the bed linen in the room. R124 stated they will make their own bed. About 30 - 40 minutes later they heard from other staff that R124 fell outside. CNA-I stated R124 took the window out and tied the sheets together from the bed frame. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/27/24, at 03:26 PM, Surveyor spoke with LPN-E. LPN-E worked the evening shift on 6/23/24. LPN-E is from an Agency and 6/23/24 was their 1st time working on the unit. LPN-E shared they relied on the 2 CNAs who were regular staff. R124 talked to the CNAs and wanted their daughter to answer the phone. LPN-E found out later R124's daughter was supposed to pick them up. The CNAs told LPN-E that the resident typically stayed in their room. LPN-E stated that when R124 paces or gets angry it means they want to leave. LPN-E stated R124 was doing that before this happened. R124 was on the 24-hour board, because the Day shift noted they were anxious. LPN-E was told they should watch the unit doors - staff said resident is anxious; watch the doors. LPN-E shared another staff told LPN-E that there was a resident on the ground. They went into R124's room and they noticed the sheets through the window. LPN-E stepped on the window glass pane that was laying on the floor. LPN-E thought the glass was pushed out and did not see it. LPN-E did not expect R124 to go through a window, The staff indicated to just keep an eye on the doors and R124 typically stayed in their room alone with the door closed. On 6/27/24, at 3:46 PM, during the daily exit meeting, Surveyor notified NHA-A and RNC-D concerns with R124. R124 did not have any comprehensive assessments/root cause analysis completed after leaving the hospital on 3/3/24 to determine R124's care needs. R124 took 3 different buses to get to their sister's house. There was not a plan of care to determine supervision needs when expressing to leave. A wander guard was placed on 5/14/24 with no correlating assessment. There was not an individualized plan of care to address R124's desire to leave the facility and the consequent behaviors of leaving or trying to leave the facility and repeatedly verbalizing wanting to go home. There was not a comprehensive assessment or plan of care to direct discharge from the facility. The facility did not provide interdisciplinary care to address medication needs, discharge requests and anxious behaviors. There was no documentation of alternatives for discharge to the community. There was not documentation or discussions for de-activating the POA. R124 performed their own cares and determined what medications they wanted to take. The facility's failure to provide medically related social services to R124 to address her desire to live at home, to assess R124's ability to make her own decisions and direct her care led to R124 to experience increased anxiety, isolation, and behaviors to convey her desire to leave. This created a situation of immediate jeopardy for R124 that resulted in R124 taking the extreme action of tying bed sheets together and removing a window to leave the facility from the second floor resulting in her falling to the ground and sustaining bilateral ankle fractures and a broken leg. The facility removed the immediate jeopardy on 7/12/24 when they implemented the following action plan: 1. R124 sent out to hospital 2. MD and POA notified. 3. Complete investigation with full RCA (root cause analysis). 4. All interviewable residents who have a BIM score 9 and above who scored high risk for Elopement and express desire to leave the facility while showing any signs and symptoms of anxiety and depression may have the potential to be affected by this alleged deficient practice. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. Check resident's wanderguard device and ensure it is functioning properly. 6. Check all wanderguards and wanderguard/alarm doors for functionality 7. Education provided to Social Service staff on Medical Social Services, Discharge Planning, Care Conference and POA activation. 8. Staff educated on Wandering and Elopement, and Behavior Monitoring. 9. All interviewable residents who have a BIM score 9 and above who scored high risk for Elopement and express desire to leave the facility while showing any signs and symptoms of anxiety and depression will be also assessed for psycho-social well-being abuse/neglect evaluation. Care plans will be reviewed and updated as needed. Care conferences addressing discharge planning will be scheduled for those who express desire to leave. 10. All interviewable residents who have a BIM score 9 and above who scored high risk for Elopement and express desire to leave the facility while showing any signs and symptoms of anxiety and depression will be reviewed by DON/designee to ensure accurate, appropriate plan of care in place. 11. Elopement and wandering binders were reviewed and updated as needed. 12. Residents who are not-interviewable are upset, anxious, and need increased supervision will be put on 24-hour board and monitored closely. 13. DON or designee will conduct audits to ensure care conferences were scheduled and held to discuss discharge planning on people who desire to leave once a week for 4 weeks. Bring results to QAPI and readdress and adjust the plan as needed. Ad hoc education to be provided as immediately as possible when indicated. 14. Audits will be reviewed at the monthly QAPI meeting to determine trends or patterns of concern and/or if further education is needed until substantial compliance has been achieved. No additional information was provided.