

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525325	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/28/2024
NAME OF PROVIDER OR SUPPLIER Bradley Estates Nursing and Rehab LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30571</p> <p>Based on staff interview, resident interview, and record review, the facility did not allow 1 resident (R) (R1) of 1 resident to remain in the facility after the resident returned from the hospital and planned to move into an apartment 11 days later.</p> <p>R1 was admitted to the hospital on 9/29/24 and returned to the facility on [DATE]. R1 planned to discharge to an apartment that was undergoing renovation and would be ready for move in on 10/20/24. Following an argument with staff on 10/9/24, R1 was told R1 had to leave the facility and was discharged to a relative's home without medication and a discharge plan.</p> <p>Findings include:</p> <p>On 10/28/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including acute on chronic diastolic heart failure, cardiomegaly (an enlarged heart), chronic kidney disease stage 3, morbid obesity, diabetes, and non-pressure chronic ulcer other part of right foot. R1's Admission Minimum Data Set (MDS) assessment, dated 7/25/24, had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R1 had intact cognition.</p> <p>A potential for activities of daily living (ADL) self-care performance deficit care plan, initiated on 7/18/24, indicated R1 was independent with self-care, dining, mobility, and transfers.</p> <p>A care plan, initiated on 7/29/24, indicated R1 wished to return to the community and would discharge home with home health services.</p> <p>Progress notes, dated 9/29/24, indicated Nurse Practitioner (NP)-Q stated R1's labs were very abnormal and R1 should be evaluated at the hospital. R1 was more short of breath than usual and R1's legs and abdomen were tight. R1 was sent to the hospital via ambulance. R1's medical record contained a Discharge Return Anticipated MDS, dated [DATE].</p> <p>A physician discharge summary, dated 10/8/24, indicated R1 was admitted to the hospital with congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD) exacerbations and had a right foot diabetic ulcer. The summary indicated R1 was stable for discharge and a basic metabolic panel (BMP) should be repeated in 1 week.</p> <p>(continued on next page)</p>

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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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A progress note, dated 10/8/24, indicated R1 returned from the hospital and was adjusting well to being back in the facility.</p> <p>Progress notes, dated 10/9/24, indicated R1 left the facility against medical advice (AMA) with R1's belongings at 2:05 PM. R1 was educated on appropriate behavior when talking with staff but continued to disrespect staff with vulgar language and refused to sign AMA paperwork. R1 was advised to follow-up with R1's primary care provider regarding medication.</p> <p>R1's medical record did not contain discharge planning paperwork. A Release of Responsibility for Discharge Against Medical Advice document, dated 10/9/24, indicated R1 discharged against medical advice. The document was not signed by R1 or a witness.</p> <p>On 10/28/24 at 9:48 AM and 10/29/24 at 12:02 PM, Surveyor interviewed R1 via phone. R1 indicated R1 was planning to discharge to an apartment on 10/1/24; however, R1 was hospitalized on [DATE] and returned to the facility on [DATE]. Nursing Home Administrator (NHA)-A entered R1's room on 10/9/24 and asked when R1 was leaving. R1 stated when R1's apartment was ready on 10/20/24. R1 was on the phone with Apartment Manager (AM)-I at the time and handed the phone to NHA-A who asked AM-I if R1 could move in sooner. When AM-I said no, NHA-A indicated R1 needed to find a shelter or somewhere to go in the meantime. R1 grabbed the phone from NHA-A and cussed (NHA-A) out. NHA-A told R1 that NHA-A wanted R1 out of the facility and the police would be called. A short time later, Maintenance Staff (MS)-H went to R1's room and said NHA-A wanted R1 out of the facility in 45 minutes. R1 asked for R1's medications which were not provided because R1 would not sign paperwork that indicated R1 was discharging AMA. R1 stated R1 would not sign paperwork that indicated they were doing me right when they were doing me wrong. MS-H and Van Driver (VD)-M drove R1 to R1's aunt's house where R1 was currently residing until R1's apartment was ready.</p> <p>On 10/28/24 at 11:47 AM, Surveyor interviewed Unit Manager (UM)-J who indicated R1 was escorted out of the facility on 10/9/24. UM-J was told R1 left AMA. When asked if R1 wanted to leave, UM-J indicated UM-J did not know if R1 wanted to leave and was told R1 would not sign AMA paperwork. UM-J indicated medications were not sent with a resident if they discharged AMA. When asked if R1 could have stayed in the facility until R1's apartment was ready, UM-J stated it was up to NHA-A.</p> <p>On 10/28/24 at 11:55 AM, Surveyor interviewed Health Unit Coordinator (HUC)-L who indicated NHA-A and Social Services (SS)-G told R1 that R1 had to leave. HUC-L indicated MS-H and VD-M left the facility with R1.</p> <p>On 10/28/24 at 11:58 AM, Surveyor interviewed SS-G who indicated R1 planned to discharge prior to R1's hospitalization. SS-G verified SS-G and NHA-A spoke with R1 about R1's discharge plan on 10/9/24 and talked to AM-I on the phone. SS-G stated R1 was swearing, hostile, and frustrated and SS-G and NHA-A were afraid R1 would hurt them. SS-G thought R1 was frustrated because NHA-A asked about R1's discharge plan. When asked if R1 was allowed to remain in the facility until R1's apartment was ready, SS-G was unsure.</p> <p>On 10/28/24 at 12:15 PM, Surveyor interviewed VD-M who verified VD-M and MS-H transported R1 to a residence on 10/9/24. VD-M stated R1 was being loud and indicated R1 was upset with NHA-A. VD-M stated R1 said R1 needed medication, however, Director of Nursing (DON)-B said R1 left AMA and would have to call R1's doctor. VD-M stated R1 said NHA-A and SS-G said R1 had to leave that day and R1's belongings were already packed.</p> <p>(continued on next page)</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/28/24 at 12:25 PM, Surveyor interviewed R12 (R1's former roommate) who indicated R1 was told R1 had to leave the facility. When asked who told R1 that R1 had to leave, R12 indicated R12 was unsure. R12 motioned toward a privacy curtain in the room and indicated the conversation occurred on the other side of the curtain.</p> <p>On 10/28/24 at 1:00 PM, Surveyor interviewed DON-B who indicated DON-B wasn't present for any conversations that occurred on 10/9/24 prior to R1's departure but was told R1 wanted to leave the facility.</p> <p>On 10/28/24 at 1:30 PM, Surveyor interviewed NHA-A who indicated R1 was supposed to discharge the day after R1's hospitalization on [DATE]. NHA-A verified NHA-A and SS-G went to R1's room on 10/9/24 to talk about R1's discharge plan. NHA-A verified NHA-A spoke with AM-I who stated R1's apartment would be ready on 10/20/24. NHA-A asked if R1 could move in sooner because R1 was ready to discharge. NHA-A verified NHA-A stated NHA-A would look at other discharge options for R1 until R1's apartment was ready. NHA-A stated R1 then grabbed the phone and got in NHA-A's face as NHA-A backed out of the room. When NHA-A said the police would be called, R1 started packing R1's belongings. NHA-A stated MS-H and VD-M dropped R1 off at what NHA-A thought was R1's sister's house. NHA-A verified R1 refused to sign AMA paperwork. When asked if R1 could have remained in the facility until R1's apartment was ready, NHA-A indicated R1 could have stayed. When asked if R1 was told R1 could stay, NHA-A indicated NHA-A and R1 did not discuss it. NHA-A reiterated that R1 was supposed to discharge on 9/30/24 and NHA-A asked R1 to expedite the process on 10/9/24 since R1 was ready to discharge. NHA-A stated it didn't make sense that R1 had an apartment to discharge to prior to R1's hospitalization but the apartment wasn't ready on 10/9/24. When asked if NHA-A stated or implied that R1 might have to go to a homeless shelter between 10/9/24 and 10/20/24, NHA-A said NHA-A could have mentioned a homeless shelter. When Surveyor asked to see the discharge plan that was prepared prior to R1's hospitalization, NHA-A stated NHA-A would check with Social Services. On 10/29/24 at 1:45 PM, Surveyor received an email from NHA-A that indicated Social Services (SS)-N had not prepared discharge paperwork for R1, including a discharge order and signed medication list, prior to or after R1's hospitalization on [DATE].</p> <p>On 10/29/24 at 12:32 PM, Surveyor interviewed AM-I who verified AM-I spoke with R1 and NHA-A via phone on 10/9/24. When AM-I indicated R1's apartment would not be ready until 10/20/24, NHA-A asked if R1 could move in sooner and then stated the facility would find a shelter for R1. AM-I heard NHA-A tell R1 that R1 had to leave the facility and heard R1 and NHA-A arguing before the phone hung up.</p> <p>On 10/29/24 at 2:52 PM, Surveyor interviewed Anonymous Staff (AS) who heard R1 and NHA-A screaming and yelling on 10/9/24 and heard R1 tell NHA-A to leave (R1) alone and get out of (R1's) face. When R1 stated R1 wasn't going anywhere, NHA-A said R1 had until 2:30 (PM) to leave. R1 asked for R1's medications and was told medications were not provided if a resident left AMA. R1 stated R1 would not sign AMA paperwork because R1 was being kicked out. AS stated R1 had just returned from the hospital and AS tried to calm R1 so R1's blood pressure would not rise and R1 would not stroke out.</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48794</p> <p>Based on observation, staff interview, and record review, the facility did not ensure 1 resident (R) (R2) of 1 resident received assistive devices to maintain vision.</p> <p>The facility did not ensure R2 obtained replacement glasses after R2's glasses were lost in the facility.</p> <p>Findings include:</p> <p>On 10/28/24, Surveyor reviewed the facility's grievance file which included a grievance, filed by R2's family member on 8/28/24, that stated R2's prescription glasses were missing. A follow-up grievance, filed by R2's family member on 8/29/24, asked for follow-up on the missing glasses. Surveyor noted the grievance did not include corrective action taken, resolution, or follow-up regarding R2's missing glasses.</p> <p>On 10/28/24, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including dementia, type 2 diabetes, cataract, glaucoma, hyperopic astigmatism and presbyopia, retinopathy, and hypertension in both eyes. R2's Minimum Data Set (MDS) assessment, dated 9/3/24, had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated R2 had severe cognitive impairment. R2's medical record indicated R2 had an activated Power of Attorney for Healthcare (POAHC) to assist with healthcare decisions.</p> <p>A HealthDrive Eye Care Group visit note, dated 5/20/24, indicated a plan for R2 to trial a frame prescription. Documentation in the Action Required by Nursing Home Staff section stated, Glasses Required: Yes, encourage full-time use for distance and reading.</p> <p>A health status note, dated 5/21/24, indicated R2 was seen by optometry. Glasses were required and would be sent after approval.</p> <p>On 10/28/24 at 4:23 PM, Surveyor observed R2 in the lounge area without glasses.</p> <p>On 10/28/24 at 3:05 PM, Surveyor interviewed Administrative Assistant (AA)-F who confirmed AA-F was the facility's Grievance Officer. AA-F acknowledged AA-F was aware R2's glasses were missing and R2's family member had filed a grievance. AA-F stated AA-F spoke with POAHC-R who reported R2's glasses had been missing for a long time. AA-F stated POAHC-R was not concerned with R2's missing glasses, therefore, replacement glasses were not obtained.</p> <p>On 10/28/24 at 4:15 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who stated if HealthDrive had ordered a trial frame, the Social Worker should have followed up on obtaining glasses. NHA-A indicated new glasses should have been obtained for R2.</p> <p>(continued on next page)</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/31/24 at 3:03 PM, Surveyor interviewed POAHC-R who stated the facility lost R2's glasses which had been missing for some time. POAHC-R stated POAHC-R had a meeting at the facility approximately 3 weeks ago and the missing glasses were discussed. POAHC-R stated the facility informed POAHC-R they would continue looking for the glasses, but offered no resolution. POAHC-R stated because of R2's diabetes, R2 needed glasses to see adequately and POAHC-R wanted R2 to have glasses.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>42423</p> <p>Based on observation, staff interview, and record review, the facility did not maintain an infection prevention and control program designed to prevent the development and transmission of communicable disease and infection for 2 residents (R) (R4 and R13) of 27 residents.</p> <p>On 10/28/24, Certified Nursing Assistant (CNA)-O carried clean towels against CNA-O's scrub top and delivered the towels to R4. In addition, CNA-O carried clean towels into 2 residents' rooms before delivering them to R13.</p> <p>Findings include:</p> <p>The facility's Infection Prevention and Control Program policy, with a revision date of 7/25/23, indicates: This facility has established and maintains an infection prevention and control program designed to provided a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections as per accepted national standards of practice .11. Linens: Laundry and direct staff shall handle, store, process and transport linens to prevent the spread of infection. Standard Precautions Infection Control Protocol: Textiles and Laundry: Handle in a manner that prevents transfer of microorganisms to others and to the environment.</p> <p>On 10/28/24 at 10:19 AM, Surveyor observed CNA-O carry a stack of folded towels from the beginning of the 200 unit hallway to the last room in the hallway (there were eleven rooms on each side of the hall from beginning to end) with the towels pressed against CNA-O's scrub top. CNA-O delivered some of the towels to R4's room and left the room. Surveyor observed R4 use the towels to wash up at the sink near the door.</p> <p>On 10/28/24 at 10:20 AM, Surveyor observed Licensed Practical Nurse (LPN)-P approach CNA-O and discuss how CNA-O was handling the remaining stack of towels. CNA-O then returned to the top of the hallway and entered a room where linens were stored. Shortly after, CNA-O exited the room with folded towels in CNA-O's hand (not against CNA-O's clothing). CNA-O carried the towels into R14's room in one hand and removed a partially consumed breakfast tray from the room with the other hand. CNA-O put the tray in a cart in the hall, walked into R15's room which had an enhanced barrier precautions (EBP) sign on the door, and then walked back into the hallway still holding the towels with one hand. CNA-O then entered R13's room and dropped off the towels.</p> <p>On 10/28/24 at 11:00 AM, Surveyor interviewed CNA-O who confirmed CNA-O delivered towels to residents' rooms and was corrected by LPN-P for handling the towels incorrectly. CNA-O indicated CNA-O put the towels that were carried against CNA-O's scrub top that had not yet been delivered into a bag to be washed. CNA-O confirmed CNA-O then carried other towels down the hall and into other residents' rooms before CNA-O delivered towels to R13.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/28/24 at 12:40 PM, Surveyor interviewed LPN-P who was observed by Surveyor watching staff on the 200 wing during the survey. LPN-P indicated LPN-P was monitoring the 200 wing. LPN-P confirmed LPN-P alerted CNA-O that clean towels for resident use should not be carried against CNA-O's clothing. LPN-P indicated CNA-O needed more training as that was not the facility's protocol for handling linens/towels and stated, That is why we have a cart. Surveyor observed the room where CNA-O retrieved the linens and noted a wheeled cart that contained linens and towels with a cover that flipped up and down to protect the items.</p>		