

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 02/06/2025
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38793</p> <p>Based on staff interview and record review, the facility did not notify a resident representative when 1 resident (R) (R3) of 1 resident accessed a loaded gun from a staff's purse and carried the gun onto a secured memory care unit. In addition, the facility did not notify the physician of a new skin concern for 1 (R2) of 1 resident</p> <p>R3 was on 1:1 direct supervision for aggressive behavior. On 1/22/25, R3 gained access to a loaded gun in a staff's purse and carried the gun onto a secured memory care unit. R3's Power of Attorney (POA) was not updated following the incident.</p> <p>On 12/20/24, a portable oxygen tank was placed on a blanket near R2's right leg while R2 was getting ready for dialysis. R2 complained of irritation to the right ankle. An assessment indicated a reddened area was present. R2's physician was not notified.</p> <p>Findings include:</p> <p>The facility's Notification of Changes Guideline, revised 7/24/19, indicates: It is the practice of this facility that changes in a resident's condition or treatment are immediately shared with the resident and/or the resident's representative, according to their authority, and reported to the attending physician or delegate. The resident and/or their representative will be educated about treatment options available .All pertinent information will be made available to the provider by facility staff .1. Requirements for notification of resident, the resident representative, and the physician .1) An accident involving the resident, which results in injury and has the potential to require physician intervention. 2) A significant change in the resident's physical, mental, or psychosocial status .3) A need to alter treatment significantly .</p> <p>1. On 1/29/25, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] and had diagnoses including dementia with agitation, metabolic encephalopathy, anxiety, and alcoholic cirrhosis. R3's most recent Minimum Data Set (MDS) assessment, dated 1/4/25, indicated R3's Brief Interview for Mental Status (BIMS) score was not assessed. A staff assessment indicated R3's memory and cognition were impaired. R3 had an activated Power of Attorney for Healthcare (POAHC) as of 1/14/25.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R3's medical record indicated R3 was on 1:1 supervision related to wandering and aggressive behaviors. Certified Nursing Assistant (CNA)-C was assigned to provide 1:1 supervision for R3 on the 1/22/25 PM shift. CNA-C brought a loaded gun into the facility in a bag in CNA-C's purse which CNA-C brought into R3's room. R3 removed the gun from CNA-C's purse and carried it onto the secured memory care unit.</p> <p>On 1/29/25 at 2:11 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who verified NHA-A was downstairs with administrative staff on 1/22/25 when NHA-A received a phone call that a resident had a gun upstairs. NHA-A instructed staff to notify the police and went upstairs to respond. NHA-A verified camera footage showed R3 carried the gun onto the secured unit. NHA-A indicated the police responded and CNA-C was charged with bringing a firearm into the facility. NHA-A indicated a police officer stated the gun was loaded and the safety was on. NHA-A verified R3's POAHC was not notified of the incident.</p> <p>40449</p> <p>2. On 1/29/25, Surveyor reviewed R2's medical record. R2 was readmitted to the facility following hospitalization for chronic hypoxemia respiratory failure on 1/9/25 and had diagnoses including right ankle soft tissue infection, neuropathy, diabetes mellitus, coronary artery disease, and anemia. R2's MDS assessment, dated 1/15/25, contained a BIMS score of 13 out of 15 which indicated R2 had intact cognition. R2 had an activated Power of Attorney (POA) who assisted with healthcare decisions.</p> <p>A health status note, dated 12/20/24 at 5:58 AM, indicated while R2 was getting ready for dialysis, a transport oxygen tank was placed on a blanket near R2's right leg. R2 complained of irritation to the right ankle. An assessment indicated a reddened area was present.</p> <p>A new skin issue observation, dated 12/20/24 at 6:09 AM, indicated R2 had a reddened area on the right inner ankle.</p> <p>A new skin issue observation, dated 12/20/24 at 1:44 PM, indicated R2 had a pre-existing wound on the right lateral ankle. Documentation did not include wound characteristics.</p> <p>On 1/29/25 at 11:00 AM, Surveyor interviewed Director of Nursing (DON)-B who reviewed R2's health status note from 12/20/24. DON-B indicated a new skin concern area should be added to the 24-hour report board and the resident's physician and responsible party (if appropriate) should be notified.</p> <p>On 1/29/25 at 11:15 AM, Surveyor interviewed Registered Nurse (RN)-K who indicated when R2 was getting ready for dialysis on 12/20/24, a portable oxygen tank was placed between R2's legs. R2 reported to RN-K the skin on R2's right lower leg felt irritated. RN-K completed a skin check and observed a reddened area on R2's right ankle. RN-K indicated the change in R2's skin should have been documented on the 24-hour report board and R2's physician and responsible party should have been notified.</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361</p> <p>Based on staff and resident representative interview and record review, the facility did not ensure a bed hold notice was provided for 1 resident (R) (R1) of 6 sampled residents.</p> <p>R1 went to the emergency room (ER) with family on 1/8/25. The facility did not provide R1 with a bed hold notice.</p> <p>Findings include:</p> <p>The facility's Bed Hold and Return Guideline policy, dated 4/25/19, indicates: It is the practice of this facility that residents who are transferred to the hospital or go on a therapeutic leave are provided with written information about the state's bed hold duration and payment amount before the transfer. Residents and their representatives will be provided with bed hold and return information at admission and before a hospital transfer or therapeutic leave. The facility will maintain contact with the resident and representative while the resident is absent from the facility and arrange for their return if appropriate. The objective of the bed hold and return to facility guideline is to ensure the resident is informed of the state's bed hold and payment and their right to return to the facility from a hospitalization or therapeutic leave if appropriate.</p> <p>1. On 2/6/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including malignant neoplasm of the bone, malignant neoplasm of the salivary gland, and repeated falls. R1's Minimum Data Set (MDS) assessment, dated 1/7/25, had a Brief Interview for Mental Status (BIMS) staff assessment that indicated R1 had no memory impairment. R1 was R1's own decision maker. R1 was admitted from the hospital due to increased falls at home and was residing at the facility for rehab services.</p> <p>On 1/8/25 at approximately 3:30 PM, R1's Family Member ((FM)-H) took R1 to the ER after a phone call to R1's cancer care team at the hospital. R1 indicated to FM-H that R1 had been waiting to see a doctor all day and did not feel well. FM-H contacted FM-I who contacted R1's hospital care team who instructed R1 to go to the ER.</p> <p>On 1/29/25 at 10:32 AM, Surveyor interviewed R1 who indicated R1 was waiting to see a physician on 1/8/25 and nobody communicated to R1 that the physician had not been in the building yet. R1 stated when FM-H came to visit, R1 did not feel well and FM-H notified FM-I who called R1's care team who told R1 to go to the ER. R1 stated nobody at the facility asked R1 about a bed hold or told R1 or FM-H about a bed hold.</p> <p>On 1/29/25 at 10:40 AM, Surveyor interviewed FM-H who indicated it was R1's first time in a nursing home. FM-H indicated FM-H did not know how things worked and nobody had told FM-H or R1. When FM-H visited R1 on 1/8/25, R1 stated R1 did not feel well and had not seen a doctor yet. FM-H contacted FM-I who contacted R1's care team at the hospital and was instructed to bring R1 to the ER. FM-H talked to someone at the facility but could not remember who. FM-H said none of the staff asked or offered anything that sounded like a bed hold when R1 left. FM-H stated, Staff saw us leaving and no one said anything.</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/29/25 at 11:50 AM, Surveyor interviewed Registered Nurse (RN)-K who worked the 1/8/25 PM shift. RN-K saw R1 leave the facility with FM-H in passing as RN-K walked onto the floor. RN-K indicated the AM nurse stated R1 had called R1's physician who indicated R1 should go to the ER. RN-K did not know when or if R1 would return.</p> <p>On 1/29/25 at 3:00 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-L who worked the 1/8/25 AM shift. LPN-L saw FM-H take R1 out of the facility. LPN-L thought FM-H was upset about something and thought FM-H was taking R1 to the ER. LPN-L heard R1 left the facility against medical advice (AMA). LPN-L thought Unit Manager (UM)-O took care of the situation. LPN-L recalled that R1 had a walker and a wheelchair with R1. LPN-L did not talk to R1 or FM-H regarding a bed hold.</p> <p>On 1/29/25 at 3:30 PM, Surveyor interviewed UM-O who stated UM-O did not offer R1 a bed hold because UM-O was not aware of what was happening. UM-O could not recall for certain but thought the facility received a phone call later on that R1 went to the ER.</p> <p>Surveyor noted R1's medical record did not indicate a bed hold notice was provided to R1 or R1's family.</p> <p>On 1/29/25 at 3:11 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated NHA-A was not sure if R1 should have received a bed hold notice because R1's family took R1 to the hospital. NHA-A agreed if a bed hold notice had been completed, staff would have known if R1 intended to come back to the facility after going to the ER.</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361</p> <p>Based on staff, resident, and family interview and record review, the facility did not ensure 1 resident (R) (R1) of 6 sampled resident was permitted to return to the facility after a hospital visit.</p> <p>R1's Family Member ((FM)-H) took R1 to the emergency room (ER) on 1/8/25. When R1 returned to the facility on [DATE], the facility informed R1 that R1 had been discharged and could not return. The facility then contacted R1 on 1/10/25 and indicated R1 could return, however, R1 was eating dinner and was settled at FM-H's for house for the night. R1 returned to the facility on [DATE].</p> <p>Findings include:</p> <p>The facility's Bed Hold and Return Guideline policy, dated 4/25/19, indicates: Residents and their representatives will be provided with bed hold and return information at admission and before a hospital transfer or therapeutic leave. The facility will maintain contact with the resident and representative while the resident is absent from the facility and arrange for their return if appropriate .C. Readmission or Return to the Facility: The facility will readmit or allow the opportunity for return to the facility when: Residents return to the facility after hospitalization or therapeutic leave if their needs can be met by the facility.</p> <p>1. On 2/6/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility for rehab on 1/3/25 due to increased falls at home. R1 had diagnoses including malignant neoplasm of the bone, malignant neoplasm of the salivary gland, and repeated falls. R1's Minimum Data Set (MDS) assessment, dated 1/7/25, had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R1 did not have memory impairment. R1 was R1's own decision maker. FM-I was listed as R1's Power of Attorney for Healthcare (POAHC) but was not activated.</p> <p>R1 had the following MDS assessments:</p> <p>~1/3/25 - Admission Entry</p> <p>~1/8/25 - Discharge-Return Not Anticipated</p> <p>~1/11/25 - Entry Tracking Record</p> <p>~1/21/25 - Discharge-Return Not Anticipated</p> <p>A physician visit note, dated 1/7/25, indicated R1 did not feel well and had loose stools.</p> <p>Medication administration notes starting on 1/8/25 at 6:27 PM indicated R1 went to the ER accompanied by family at approximately 3:30 PM. (R1's medical record did not indicate R1 did not feel well and requested to see a physician on 1/8/25 and did not indicate a bed hold notice was provided when R1 was taken to the ER by family.)</p> <p>(continued on next page)</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A progress note, dated 1/9/25 at 2:09 AM and written by Unit Manager (UM)-M, indicated family took R1 to the hospital with R1's belongings.</p> <p>A progress note, dated 1/9/25 at 4:24 PM and written by Director of Nursing (DON)-B, indicated R1 was discharged against medical advice (AMA) on 1/8/25 at 3:00 PM. R1 and FM-H attempted to return to the facility on [DATE] at 4:15 PM. DON-B explained why R1 was not being accepted back and indicated R1 and FM-H needed a new referral. R1 and FM-H were upset but understood the process and left the facility. R1 and FM-H said they had medication at home for R1 and would call R1's physician. DON-B indicated the facility would take R1 back with a proper referral.</p> <p>On 1/29/25 at 10:32 AM, Surveyor interviewed R1 who indicated R1 was waiting to see a doctor on 1/8/25 but nobody had communicated to R1 that the doctor had not been in the building yet. R1 stated when FM-H came to visit, R1 stated R1 did not feel well. FM-H called FM-I who called R1's care team who told R1 to go to ER. R1 and FM-H left the ER between 1:00 and 2:00 AM (on 1/9/25). FM-H and R1 were not sure if they could get back in the facility so R1 went home with FM-H. R1 returned to the facility later in the day on 1/9/25 but was sent home. R1 stated the facility called the following day (1/10/25) and said R1 could come back. R1 did not understand why that happened because R1 went to the ER based on instructions from the hospital. R1 stated when R1 left the facility, nobody told R1 about the process for leaving or returning. R1 stated R1 did not have a lot of personal items in R1's room because R1 had only been at the facility a few days. R1 took what R1 had to the ER (which was mostly bathroom items) because R1 did not know if R1 would be admitted to the hospital.</p> <p>On 1/30/25 at 10:40 AM, Surveyor interviewed FM-H who indicated it was R1 and R1's family's first time dealing with a nursing home. FM-H did not know how things worked and indicated nobody at the facility informed FM-H or R1 of the process for leaving or returning. FM-H visited R1 on 1/8/25 at approximately 3:00 PM. R1 stated R1 did not feel well, had not seen a doctor that day, and staff had not come in. FM-H contacted FM-I who contacted R1's care team at the hospital who instructed FM-H to bring R1 to the ER. FM-H talked to an unidentified person at the facility and stated staff at the front desk knew R1 and FM-H had left. FM-H told an unidentified staff that R1 would be back eventually. FM-H and R1 took R1's walker and wheelchair and the few personal items R1 had because they did not know if R1 would be admitted to the hospital. FM-H stated they left the ER between 1:00 and 2:00 AM (on 1/9/25). FM-H was not sure if staff would let R1 back in the facility that late so FM-H took R1 home. R1 slept in and returned to the facility in the afternoon with FM-H. When FM-H took R1 to R1's room, staff told R1 that R1 had been discharged and indicated R1 had to go back to the hospital and get another referral. FM-H and R1 left the facility. FM-H stated the facility called later in the day on 1/10/25 and said R1 could return. Since R1 was eating dinner and settled in for the night, R1 and FM-H told the facility R1 would return in the morning (on 1/11/25).</p> <p>(continued on next page)</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/29/25 at 10:00 AM, Surveyor interviewed FM-I who indicated FM-I received a phone call from FM-H that R1 did not feel well, wanted to see a doctor, and had been waiting all day. R1 requested to see a physician in the morning and staff indicated the physician would be in later that day. FM-I called R1's cancer care team who advised R1 to go to the ER. FM-I informed FM-H who informed staff and took R1 to the ER. FM-I indicated FM-H and R1 left the ER at 1:00 AM. FM-H was not sure if they could back get in the facility that late so FM-H took R1 to FM-H's house for the rest of the night. R1 slept in on 1/9/25 and returned to the facility in the afternoon. When R1 returned, staff indicated R1 had been discharged and needed to go back to the hospital to get another referral. FM-I indicated the facility did not give R1 or FM-H any discharge paperwork. FM-I made phone calls to several individuals including Ombudsman (OMB)-J who contacted Nursing Home Administrator (NHA)-A. FM-I indicated the facility contacted R1 at approximately 5:00 PM on 1/10/25 and said R1 could return. Since R1 was already eating dinner and had settled in for the evening, R1 returned to the facility on the morning of 1/11/25.</p> <p>On 1/29/25 at 10:55 AM, Surveyor interviewed OMB-J who confirmed FM-I contacted OMB-J and OMB-J contacted NHA-A. OMB-J indicated it sounded like there were miscommunications and verified the facility did not accept R1 back when R1 returned from the ER. NHA-A was told R1 left with FM-H, took all of R1's belongings, and was not coming back. OMB-J educated NHA-A that the facility needed to accept R1 back. OMB-J indicated NHA-A seemed to understand and ended up taking R1 back. OMB-J indicated it was an opportunity to provide education.</p> <p>On 1/29/25 at 11:50 AM, Surveyor interviewed Registered Nurse (RN)-K who worked the 1/8/25 PM shift. RN-K arrived on the floor late and saw R1 leave the facility in passing. RN-K indicated the AM shift nurse said R1 called R1's physician who told R1 to go to the ER. RN-K did not know when or if R1 would return.</p> <p>On 1/29/25 at 1:53 PM, Surveyor interviewed UM-M who documented on 1/9/25 at 2:09 AM that family took R1 and R1's belongings to the hospital. UM-M indicated the previous shift said FM-H had taken R1 and R1's belongings to the ER but did not provide any details. UM-M documented the information and indicated UM-M did not know if R1 left AMA since there was no discharge summary or interdisciplinary note that stated R1 discharged .</p> <p>On 1/29/25 at 2:20 PM, Surveyor interviewed DON-B who indicated FM-H packed R1 and took R1 to the hospital and R1 was not returning. DON-B indicated UM-O talked to FM-H and R1 when they returned on 1/9/25. DON-B indicated R1 and FM-H seemed to understand what they needed to do and left the facility. DON-B indicated the regional office made the decision not to accept R1 back at that time, however, R1 was accepted back after conversations with OMB-J. DON-B acknowledged there could have been more documentation or a phone call to R1 or R1's family about what was happening if staff were unsure.</p> <p>On 1/29/25 at 2:40 PM, Surveyor interviewed Receptionist (RCP)-N who worked the front desk on 1/8/25 when FM-H took R1 to the ER. RCP-N indicated FM-H took R1 out, brought R1 back the next day, and left with R1 again a short time later. RCP-N indicated FM-H stated FM-H was taking R1 to the ER because R1 did not feel well. RCP-N thought it was odd because residents were usually sent to the ER via ambulance. RCP-N asked if FM-H had signed R1 out or if FM-H had told anyone. FM-H indicated FM-H had spoken to a nurse. When Surveyor asked if R1 took R1's belongings, RCP-N could not recall but thought there was a wheelchair and a walker and thought R1 had a purse in R1's lap.</p> <p>(continued on next page)</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/29/25 at 3:00 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-L who worked the 1/8/25 AM shift. LPN-L indicated FM-H took R1 to the ER. LPN-L did not know details but knew FM-H took R1's walker and wheelchair. LPN-L was not aware and was not told that R1 was waiting to see the physician and thought UM-O was handling the situation.</p> <p>On 1/29/25 at 3:30 PM, Surveyor interviewed UM-O who indicated UM-O did not know what occurred but heard FM-H took R1 and R1's belongings to the ER. UM-O indicated if R1 left AMA, the facility would not provide a bed hold notice. UM-O recalled that R1 did not feel well and FM-I wanted R1 to go to the hospital.</p> <p>On 1/29/25 at 3:11 PM, Surveyor interviewed NHA-A who indicated R1 was accepted back after a conversation with OMB-J. NHA-A was told that R1 was out on a pass with R1's belongings and did not return. NHA-A stated R1's personal belongings were gone and staff thought R1 left AMA since R1 did not return after midnight so R1 was discharged . NHA-A indicated when R1 showed up at the facility the next day, staff did not know what happened at the ER, did not have an updated medication list, and had already discharged R1. NHA-A indicated R1 was not told that R1 could not come back but was told that R1 had to go back to the ER and get the information the facility needed to be able to readmit R1. NHA-A explained to OMB-J why the facility made the decisions they did and indicated OMB-J stated the facility had to readmit R1 per the regulation. NHA-A verified there should have been more documentation in R1's medical record about what occurred. NHA-A again indicated NHA-A was not informed that R1 went to the ER with family.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38793</p> <p>Based on staff and resident interview and record review, the facility did not ensure the resident environment remained as free of accident hazards as possible for 1 resident (R) (R3) of 1 resident (with the potential to affect 26 of 141 other residents) when R3 obtained a loaded firearm from a staff's bag and carried it onto a secured memory care unit and for 1 (R2) of 1 resident who incurred a third degree cryogenic burn from a portable oxygen tank that was placed on the foot pedals of the resident's wheelchair.</p> <p>R3 was on 1:1 supervision related to wandering and aggressive behavior toward staff. Certified Nursing Assistant (CNA)-C was assigned to complete 1:1 supervision for R3 on the 1/22/25 PM shift. CNA-C brought a loaded gun into the facility in a purse and brought the purse into R3's room. R3 removed the gun from CNA-C's purse and carried the gun onto a secured memory care unit. Staff intervened and removed the gun. In addition, Dialysis Registered Nurse (DRN)-R observed R2 in a wheelchair in the elevator on the way to a dialysis appointment. When R2 complained of pain, DRN-R observed a leaking portable oxygen tank on the foot pedals of R2's wheelchair that was placed there by staff. DRN-R noted a reddened area on R2's right foot and notified facility staff. The wound was not monitored or treated until 12/28/24 when staff discovered a full-thickness third degree cryogenic burn on R2's right lateral ankle/heel that required surgical debridement and antibiotic treatment for infection.</p> <p>The facility's failure to ensure a safe environment when staff placed a portable oxygen tank on the foot pedals of a resident's wheelchair led to a finding of immediate jeopardy that began on 12/24/24. The immediate jeopardy was removed and corrected on 12/28/24. Nursing Home Administrator (NHA)-A was notified of the immediate jeopardy on 2/21/25 at 4:15 PM. In addition, the facility's failure to ensure a safe environment when staff brought a loaded gun onto a secured memory care unit and a resident on 1:1 supervision retrieved the gun and carried it onto the unit led to a finding of immediate jeopardy that began on 1/22/25. NHA-A was notified of the immediate jeopardy on 1/29/25 at 4:14 PM. The immediate jeopardy was removed on 1/29/25, however, the deficient practice continues at a scope/severity level E (potential for more than minimal harm/pattern) as the facility continues to implement its action plan.</p> <p>Findings include:</p> <p>According to Mental Health America, exposure to violent events cause trauma and lasting changes in the nervous system in both children and adults. Exposure to all types of violence, and the toxic stress caused by fear of violence, are shown to negatively impact psychosocial engagement and increase the likelihood of a person developing mental health conditions at all stages of life. (https://www.mhanational.org/gun-deaths-violence-and-mental-health)</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Bradley Estates Nursing and Rehab LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6735 W Bradley Rd Milwaukee, WI 53223	
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>According to the American Society on Aging, firearm violence or exposure to it can affect both physical and mental health. Some people with exposure to firearm violence may experience post-traumatic stress disorder (PTSD), anxiety, or other conditions as a result. Disability, both short-term and long-term, also may result from firearm violence and vary in severity and impact. Such disabilities affect family structure, family financial status and family health. (https://generations.asaging.org/firearm-violence-and-older-adults#:~:text=Some%20people%20who%20have%20been,vary%20in%20severity%20and%20impact.)</p> <p>1. On 1/29/25, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] and had diagnoses including dementia with agitation, metabolic encephalopathy, anxiety, and alcoholic cirrhosis. R3's most recent Minimum Data Set (MDS) assessment, dated 1/4/25, indicated R3's Brief Interview for Mental Status (BIMS) score was not assessed. A staff assessment indicated R3's memory and cognition were impaired. R3 had an activated Power of Attorney for Healthcare (POAHC) as of 1/14/25.</p> <p>R3's most recent comprehensive care plan, dated July 2024, indicated R3 had negative behavioral disturbances related to depression, insomnia, and general anxiety. R3's behaviors included verbal and physical aggression toward staff. R3's care plan did not contain an intervention for 1:1 supervision, however, progress notes stated to continue with 1:1 supervision and staff were specifically assigned 1:1 supervision for R3 on the schedule.</p> <p>On 1/29/25, Surveyor investigated an incident that occurred on 1/22/25 when CNA-C was assigned to provide 1:1 supervision to R3 on the secured memory care unit. During the shift, R3 retrieved a loaded gun from CNA-C's purse when CNA-C asked CNA-E to watch R3 while CNA-C took a break. R3 carried the gun onto the secured memory care unit where 26 other residents resided.</p> <p>On 1/29/25 at 9:45 AM, Surveyor interviewed CNA-F regarding residents who require 1:1 supervision. CNA-F indicated there was one resident who currently required 1:1 supervision (R4). When asked if there were any concerns with other residents who had been on 1:1 supervision, CNA-F stated there was an incident where R3 found a gun in R3's 1:1 staff's bag.</p> <p>On 1/29/25 at 10:51 AM, Surveyor interviewed CNA-E regarding the incident on 1/22/25. CNA-E verified CNA-E worked the 1/22/25 PM shift on the 500 unit. CNA-E stated CNA-E took over 1:1 supervision for R3 when CNA-C took a 15 minute break. CNA-E observed R3 in the dining room while CNA-E set up for dinner. CNA-E then observed R3 exit the dining room and walk toward R3's room (which was two doors down from the dining room). CNA-E followed R3 and observed from the hallway as R3 was rummaging through a black bag in the room. CNA-E then observed R3 walk out of the room with something in R3's hand. After approximately 30 seconds, CNA-E realized R3 was carrying a gun and immediately notified Licensed Practical Nurse (LPN)-D. CNA-E stated R3 was on 1:1 supervision related to aggressive behavior at that time.</p> <p>On 1/29/25 at 12:36 PM, Surveyor interviewed CNA-C regarding the incident on 1/22/25. CNA-C verified CNA-C was assigned to 1:1 supervision for R3 on the 1/22/25 PM shift. CNA-C stated CNA-C was sitting in the dining room with R3 just before dinner when CNA-C asked CNA-E to take over for 15 minutes so CNA-C could take a break. CNA-C was on break for approximately 10 minutes when CNA-C became aware of the incident. CNA-C verified the gun was in CNA-C's purse that was left in R3's room. CNA-C verified the gun was loaded and stated the safety was on. CNA-C indicated CNA-C was aware that guns were not allowed in the facility, however, CNA-C was in a hurry that morning and forgot about the gun.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 1/29/25 at 3:38 PM, Surveyor interviewed LPN-D regarding the incident on 1/22/25. LPN-D was checking on another resident on the unit when LPN-D observed R3 exit R3's room with something in R3's hand. At first LPN-D thought R3 was carrying a toy gun, but upon closer inspection noticed the gun was real. LPN-D asked R3 for the gun and put the gun back in a black bag in R3's room and closed the door. LPN-D then notified NHA-A and Director of Nursing (DON)-B. LPN-D stated LPN-D did not receive any training related to the incident.</p> <p>On 1/29/25 at 2:11 PM, Surveyor interviewed NHA-A regarding the incident on 1/22/25. NHA-A verified NHA-A was downstairs with administrative staff on 1/22/25 when NHA-A received a phone call that a resident had a gun upstairs. NHA-A instructed staff to notify the police and went upstairs to respond. By the time NHA-A arrived on the unit approximately 5 minutes later, LPN-D had retrieved the gun from R3. NHA-A verified camera footage showed R3 carried the gun onto the secured memory care unit. NHA-A indicated staff education was started on 1/22/25 regarding personal belongings in residents' rooms, active violence training, and active shooter drills. NHA-A indicated the police arrived and CNA-C was charged with bringing a firearm into the facility. NHA-A verified the police officer stated the gun was loaded and the safety was on.</p> <p>On 1/29/25, Surveyor reviewed a police report related to the incident. The report indicated police were dispatched for a subject with weapon complaint on the second floor of the facility on 1/22/25 at 4:05 PM. Officers made contact with NHA-A who informed them CNA-C came to work with a gun in CNA-C's purse despite the fact there was a sign on the front door that stated employees were prohibited from possessing firearms in the building. CNA-C was arrested and a black 9 mm gun was recovered.</p> <p>The failure to ensure the resident environment was as free from accident hazards as possible and prevent a cognitively impaired resident access to a loaded gun created a reasonable likelihood for serious harm which led to a finding of immediate jeopardy. The facility removed the jeopardy on 1/29/25 when it completed the following:</p> <ol style="list-style-type: none"> 1. Notified the police and removed the employee and firearm from the building. 2. Educated all staff on personal belongings, active violence training, and active shooter drills. 3. Initiated psychosocial monitoring for all residents on the 500 unit. 4. Initiated audits to ensure weapons are not brought into the facility. <p>40449</p> <p>2. On 1/29/25, Surveyor reviewed R2's medical record. R2 was readmitted to the facility on [DATE] following hospitalization for chronic hypoxemic respiratory failure and had diagnoses including right ankle soft tissue infection, neuropathy, diabetes mellitus, coronary artery disease, and anemia. R2's MDS assessment, dated 1/15/25, had a BIMS score of 13 out of 15 which indicated R2 had intact cognition. R2 had an activated Power of Attorney (POA) who assisted with R2's healthcare decisions.</p> <p>A health status note, dated 12/20/24 at 5:58 AM, indicated a transport oxygen tank was placed on a blanket near R2's right leg when R2 was getting ready to go to dialysis. R2 complained of right ankle irritation. An assessment indicated a reddened area was present with no break in the skin. The note stated, Continued to be monitored.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>A skin issue observation, dated 12/20/24 at 6:09 AM, indicated R2 had a reddened area on the right inner ankle.</p> <p>A skin issue observation, dated 12/20/24 at 1:44 PM, indicated R2 had a pre-existing wound on the right lateral ankle. The observation did not include wound characteristics or measurements.</p> <p>A weekly skin review and a skin and bath report, both dated 12/24/24, as well as diabetic foot checks completed from 12/20/24 through 12/27/24 did not indicate there were any concerns with R2's right ankle/heel.</p> <p>A skin observation, dated 12/28/24, indicated R2 had a flat dark-colored blister on the right lateral heel and a pre-existing wound on the right lateral ankle.</p> <p>A health status note, dated 12/28/24 at 11:25 AM, indicated R2 had a flat blister with dark discoloration on the right heel. The peri-wound (surrounding skin) was peeling with no drainage or odor. The wound measured 5.6 centimeters (cm) x 4.9 cm.</p> <p>A Nurse Practitioner (NP) visit note, dated 12/28/24, indicated R2 had a flat right heel blister with dark discoloration to the tissue that measured 5.6 cm x 4.9 cm.</p> <p>A skin and wound evaluation, dated 12/30/24, indicated R2 had an in-house acquired third degree burn on the right medial malleolus (note: the wound was on the lateral side of the foot) that contained eschar, redness, inflammation, erythema (swelling), and light serous (clear or pale yellow) exudate (drainage). The wound had blistered surrounding tissue and measured 4.5 cm x 4.3 cm.</p> <p>An NP visit note, dated 12/30/24, indicated R2 had a right medial ankle wound (an addendum was added to indicate the wound was on the right lateral ankle) status-post cryogenic burn from liquid oxygen in a tank that was placed between R2's legs in a wheelchair. The wound measured 4.5 cm x 4.32 cm x depth unable to be determined. R2 reported moderate to severe pain. Doxycycline (an antibiotic used to treat infection) and hydrocodone-acetaminophen (Norco) (an opioid medication used to treat pain) were ordered. R2 stated the incident occurred the previous Tuesday (12/24/24). (R2's December 2024 Medication Administration Record (MAR) contained an order initiated on 12/30/24 for doxycycline hyclate 100 milligrams (mg) twice daily for wound infection for 14 days.)</p> <p>A wound physician initial visit note, dated 1/3/25, indicated R2 had a full thickness burn (a severe burn that destroys all three layers of the skin) on the right lateral heel that measured 5.0 cm x 5.0 cm x 0.1 cm with light serous exudate and 100% necrotic tissue. The wound physician ordered silver sulfadiazine with an ABD pad and gauze roll twice daily for 30 days. The note indicated debridement was attempted but aborted due to pain and debridement with sharps was contraindicated due to R2's risk of bleeding.</p> <p>R2 was hospitalized from 1/5/25 to 1/9/25 for issues related to respiratory failure. A hospital discharge summary, dated 1/9/25, indicated R2 had a right ankle soft tissue infection from a burn caused by a frozen oxygen tank. The wound had eschar, surrounding erythema, and a foul odor.</p> <p>An infectious disease note, dated 1/8/25, indicated R2 had bedside mechanical debridement on 1/1/24 (note: should be 1/1/25) at the facility by an on-site wound care provider. The team was concerned about persistent and foul odor and a skin and soft tissue infection.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 1/29/25 at 10:23 AM, Surveyor interviewed Wound Care Consultant (WCC)-P who indicated R2's right heel wound was discovered on 12/28/24. WCC-P verified the wound on R2's right heel (which is the same wound that was described as a right lateral ankle wound) was a burn related to a portable oxygen tank.</p> <p>On 1/29/25 at 11:00 AM, Surveyor interviewed DON-B who indicated a new open area should be added to the 24-hour report board and the resident's physician and responsible party (if appropriate) should be updated.</p> <p>On 1/29/25 at 11:15 AM, Surveyor interviewed Registered Nurse (RN)-K who indicated when R2 was getting ready for dialysis on 12/20/24, a portable oxygen tank was put between R2's legs. R2 reported to RN-K that the skin on R2's right lower leg felt irritated. RN-K completed a skin check and observed a reddened area on R2's right ankle. RN-K indicated the change in R2's skin should have been documented on the 24-hour report and R2's physician and responsible party should have been notified. RN-K thought the proper documentation was completed but was later notified by DON-B that RN-K had not documented on the 24-hour report board.</p> <p>On 1/29/25, Surveyor reviewed the 24-hour report from 12/20/24. The 24-hour report did not contain documentation related to R2's right ankle irritation on 12/21/24, 12/22/24, 12/24/24, 12/25/24, 12/26/24, or 12/27/24. The 24-hour reports for 12/20/24, 12/23/24, and 12/28/24 were not provided. On 12/29/24, the 24-hour report indicated R2 had a right heel wound.</p> <p>On 1/29/25 at 11:45 AM, Surveyor interviewed R2 who indicated a portable oxygen canister was placed between R2's legs prior to dialysis. R2 reported to a nurse that R2's feet hurt. The nurse completed an assessment and told R2 there were no concerns. R2 reported the concern to a dialysis nurse as well. R2 indicated despite lower extremity neuropathy (a condition that damages the nerves), R2 could feel the increased pain.</p> <p>On 1/29/25 at 12:45 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-Q who indicated R2 complained of foot pain on 12/28/24. LPN-Q observed a wound on R2's right lateral heel. LPN-Q indicated the wound had a blister-like appearance with a flat and hard wound bed.</p> <p>The facility's investigation indicated the area was likely first irritated on 12/20/24 despite R2's statement that the injury occurred on 12/24/24. Staff believe the area was reinjured on 12/24/24 on R2's way to dialysis.</p> <p>A statement by NHA-A, dated 12/31/24, indicated NHA-A was informed on 12/28/24 of an open area on R2's leg and it was bad. The note indicated R2 was going to be sent to the hospital but an on-call NP did not want R2 to go to the hospital and wanted to assess R2 in the facility. The on-call NP assessed R2 and indicated the area was a stage 2 pressure injury and not a burn.</p> <p>A statement by DRN-R, dated 12/31/24, indicated DRN-R saw R2 in the elevator (the statement did not contain the date) and noticed air coming from R2's portable oxygen tank. When R2 arrived on the unit, R2 complained of lower right leg pain. DRN-R assessed R2, observed a red spot (the note did not specify where the red spot was observed), and notified facility staff of the observation.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>A statement by LPN-Q, dated 12/31/24, indicated R2 asked LPN-Q to look at R2's feet on 12/28/24 because R2's feet were burning. LPN-Q observed a flat wound on R2's right foot that was peeling around the edges and appeared to be a popped blister. R2 indicated an oxygen tank was lying down there when R2 was at dialysis. R2 stated the tank leaked, R2's covers were wet, and R2's foot was burning. R2 told staff who stated they didn't see anything at that time. While LPN-Q was talking to R2, CNA-T indicated there was blood on R2's sheets the day before and CNA-T did not know where the blood came from.</p> <p>An undated statement by CNA-T indicated CNA-T found blood like discharge and coffee like stains in R2's bed under R2's foot on 12/28/24. R2 reported pain. CNA-T observed the bottom of R2's foot and notified a nurse.</p> <p>A statement by Unit Manager (UM)-M, dated 12/30/24, indicated UN-M assessed the right side of R2's foot just below the ankle on 12/28/24 after R2 reported pain. R2 indicated a CNA put a portable oxygen tank between R2's legs on 12/24/24 prior to transporting R2 to dialysis. R2 reported pain to DRN-R who removed the tank and notified a facility nurse of R2's complaint.</p> <p>The failure to ensure liquid oxygen did not come in contact with a resident's skin and the failure to assess and treat the skin following a cryogenic burn led to serious harm for R2 who developed a full-thickness third degree burn and required antibiotic treatment for infection. The facility removed the jeopardy on 12/28/24 when it completed the following:</p> <ol style="list-style-type: none"> 1. Educated licensed and certified staff on the facility's Oxygen Usage policy and procedure. 2. Checked all resident and stock portable oxygen tanks to ensure proper function. 3. Completed skin assessments on all residents who use portable oxygen tanks. 4. Reviewed and/or revised the care plans of all residents at risk for oxygen burns. 		