

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 06/10/2025
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 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of resident council meeting minutes, the facility failed to act upon the grievances raised during resident council and demonstrate their response and rationale for such response. This failure had the potential to affect the quality of life of more than 4 of the 132 residents residing in the facility.</p> <p>Findings include:</p> <p>1. Resident Council Meeting Minutes, dated 1/22/25, indicated: .New Business and Concerns: a. Snacks not being passed; b. Call lights are not being answered on 1st and 3rd shift; c. Giving care while on the phone; d. Sitting in the hallway on the phone while call light on; e. Staff are rarely on the units .</p> <p>Resident Council Meeting Minutes, dated 2/20/25, indicated: .Old Business: a. Staff on the phone while giving care and passing food trays .</p> <p>Resident Council Meeting Minutes, dated 3/25/25, indicated: .Old Business: a. Staff are still on the phone while giving care or just sitting in room on phone .</p> <p>Resident Council Meeting Minutes, dated 4/28/25, indicated: .Old Business: a. Call lights are not being answered by staff sitting behind nurses' station talking with management .</p> <p>There was no documented evidence that the facility acted upon the residents' grievances and provided a response to the resident council concerns.</p> <p>Call light audits provided by the facility indicated:</p> <p>~ 1/13/25 on unit 100</p> <p>~ 2/7/25 (did not reveal the unit audited)</p> <p>~ 2/14/25 on unit 300</p> <p>~ 2/11/25 on hall 400</p> <p>~ 4/16/25 on hall 200</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 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>~ 4/30/25 on hall 200</p> <p>There was no documented evidence of the results of the call light audits.</p> <p>2. R3's Quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 3/20/25, revealed R3 was admitted to the facility on [DATE]. R3 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R3 was cognitively intact.</p> <p>During an interview on 6/10/25 at 5:09 PM, R3 stated the only ongoing problem was that staff always sit at the nursing station on their phones and do not respond to residents. R3 stated the majority of staff are always on their cell phones. R3 stated, It is horrible. R3 stated when R3 walks past the nursing station, R3 can see the lights on the board. R3 indicated once there were ten lights going off and staff were sitting there on their phones. R3 stated R3 and other residents had mentioned the issue of delayed call light response times during resident council and had told staff, but nothing was done and it was still happening.</p> <p>3. R5's Annual MDS assessment, with an ARD of 3/02/25, revealed R5 was admitted to the facility on [DATE] and readmitted on [DATE]. R5 had a BIMS score of 14 out of 15 which indicated R5 was cognitively intact.</p> <p>Review of the facility's grievance log revealed R5 filed a grievance on 2/3/25 related to call lights.</p> <p>During an interview on 6/10/25 at 5:40 PM, R5 stated staff do not come right away and take a long time when R5 activates the call light. R5 stated sometimes staff come but do not change R5. R5 stated staff just pop in and they disappear again leaving R5 unchanged until the next shift comes. When asked if R5 reported the concern to anyone, R5 stated the head nurse knows but they do nothing. R5 stated, They come and ask questions but they do nothing. When asked if R5 or anyone else brought up call light issue during resident council, R5 said it was discussed and stated, Things have not changed. They sure take a long time before they respond.</p> <p>4. R4's Quarterly MDS assessment, with an ARD of 2/20/25, revealed R4 was admitted to the facility on [DATE] and readmitted on [DATE]. R4 had a BIMS score of 15 out of 15 which indicated R4 was cognitively intact.</p> <p>Review of the facility's grievance log revealed R4 filed a grievance on 2/13/25 related to call lights.</p> <p>During an interview on 6/10/25 at 5:47 PM, R4 stated, Sometimes, the aides are very rude. They don't answer call lights in time. It takes forever. R4 stated the matter was discussed during resident council but it was still happening.</p> <p>5. R9's Quarterly MDS assessment, with an ARD of 3/10/25, revealed R9 had a BIMS score of 9 out of 15 which indicated R9 was moderately cognitively impaired.</p> <p>During an interview on 6/10/25 at 5:51 PM, R9 stated R9 did not have a problem with call light response times because R9 was independent, however, R9's roommate's (R10's) light was not answered right away.</p> <p>(continued on next page)</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/10/25 at 4:22 PM, Nursing Home Administrator (NHA) A was asked how the facility addressed and resolved grievances raised during resident council. NHA A stated the way the facility responds to issues raised in resident council is to turn them into grievances and find a resolution that way. NHA A stated the grievance log demonstrated R4 and R5 had grievances for call lights, dated 2/13/25 and 2/3/25 respectively, that were addressed and resolved through call light audits and education. NHA A was asked to provide documentation that the facility had addressed the residents' concerns related to call lights and staff talking on their phones, including a response to the resident council. NHA A stated call light audits were completed. When asked about the results of the call light audits, NHA A stated the former NHA had completed the audits and NHA A had no further information to add.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility policy review, and insulin pen manufacturer's instructions, the facility failed to ensure 2 residents (R) (R6 and R7) of 2 residents observed during medication administration were provided insulin from an insulin pen per the manufacturer's instructions. This failure had the potential for R6 and R7 to receive an incorrect dose of their insulin.</p> <p>Findings include:</p> <p>The facility's Administering Medications policy, revised 5/2025, indicates: .Medications shall be administered in a safe and timely manner, and as prescribed .</p> <p>The insulin pen manufacturer's patient instructions, located at http://uspl.lilly.com/humalog/humalog.html#ug1, indicate: .Step 11: Insert the needle into your skin. Push the dose knob all the way in. Continue to hold the dose knob in and slowly count to 5 before removing the needle</p> <p>1. R6's Annual Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 2/19/25, revealed R6 was admitted to the facility on [DATE] and had a diagnosis of diabetes mellitus. It was recorded R6 received insulin injections on 7 of 7 of the preceding days.</p> <p>R6 had a physician order, dated 3/7/25, that indicated: Humalog KwikPen subcutaneous solution pen injector 100 unit/ml (milliliter) (insulin lispro) inject as per sliding scale .subcutaneously before meals and at bedtime .</p> <p>During an observation on 6/10/25 at 5:29 PM, Licensed Practical Nurse (LPN) 2 administered four units of insulin lispro subcutaneously into R6's abdomen using a Humalog KwikPen subcutaneous solution pen injector. LPN 2 injected the insulin and immediately withdrew the pen needle. LPN 2 did not hold the pen for at least five seconds per manufacturer's guidelines before withdrawing the needle.</p> <p>During an interview on 6/10/25 at 5:28 PM, LPN 2 confirmed LPN 2 administered the insulin injection to R6 and immediately withdrew the needle.</p> <p>2. R7's Quarterly MDS assessment, with an ARD of 4/28/25, revealed R7 was readmitted to the facility on [DATE] and had a diagnosis of type 2 diabetes mellitus.</p> <p>R7 had a physician order, dated 4/7/25, that indicated: Humalog KwikPen subcutaneous solution pen injector 100 unit/ml (insulin lispro) inject as per sliding scale .subcutaneously before meals for DM (diabetes mellitus) .</p> <p>During an observation on 6/10/25 at 5:54 PM, LPN 1 administered four units of insulin lispro subcutaneously in R7's right forearm using a Humalog KwikPen subcutaneous solution pen injector. LPN 1 injected the insulin and immediately withdrew the pen needle. LPN 1 did not hold the pen for at least five seconds per manufacturer's guidelines before withdrawing the needle.</p> <p>During an interview on 6/10/25 at 5:57 PM, LPN 1 confirmed LPN 1 did not hold the injection for R7 for five seconds before withdrawing the needle.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/10/25 at 6:43 PM, Unit Manager (UM) 1 was informed of the observations and was asked about the facility's policy for administering insulin with an insulin pen. UM 1 stated the instructions for the use of insulin pens could be found online on the manufacturer's website.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observation, interview, facility policy review, and manufacturer's instructions, the facility failed to ensure multi-dose insulin pens were labeled with the date and time when first opened for 2 residents (R) (R6 and R7) of 2 residents observed during medication administration. This failure had the potential to expose R6 and R7 to expired medications.</p> <p>Findings include:</p> <p>The facility's Administering Medications policy, revised 5/2025, indicates: .Medications shall be administered in a safe and timely manner, and as prescribed .The expiration/beyond use date on the medication label must be checked prior to administration. When opening a multi-dose container, the date opened shall be recorded on the container .</p> <p>The facility's Insulin Administration policy, revised 9/2014, indicates: .Check expiration date if drawing from an opened multi-dose vial. If opening a new vial, record expiration date and time on the vial (follow manufacturer recommendations for expiration after opening) .</p> <p>The Humalog Pen manufacturer's patient instructions, located at https://uspl.lilly.com/humalog/humalog.html#ug1, indicate: .Throw away the Humalog pen you are using after 28 days, even if it still has insulin left in it .</p> <p>1. During an observation on 6/10/25 at 5:27 PM, Licensed Practical Nurse (LPN) 2 retrieved a new Humalog KwikPen subcutaneous solution pen injector 100 unit/milliliter (ml) (insulin lispro) insulin pen from the medication cart and administered four units of insulin to R6. LPN 2 did not label the pen with the date opened.</p> <p>On 6/10/25 at 5:28 PM, LPN 2 returned the insulin pen to the medication cart. When asked how long the pen was good after being opened, LPN 2 stated, Twenty eight days. When LPN 2 was asked how the next nurse would know when the pen was opened, LPN 2 stated, It is the only pen in there that is open.</p> <p>2. During an observation on 6/10/25 at 5:54 PM, LPN 1 withdrew an open Humalog KwikPen subcutaneous solution pen injector 100 unit/ml (insulin lispro) insulin pen from the medication cart and administered four units of insulin to R7. The insulin pen was not labeled with an open date.</p> <p>During an interview on 6/10/25 at 5:57 PM, LPN 1 was asked when the pen was opened. LPN 1 stated LPN 1 did not know and was just an agency nurse. When asked how long the pen was good after being opened, LPN 1 stated, Ninety days.</p> <p>During an interview on 6/10/25 at 6:43 PM, Unit Manager (UM) 1 stated insulin pens are good for twenty eight days after opening. UM 1 stated it is UM 1's expectation that once opened, each insulin pen is labeled with the open and discard dates.</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>Based on observation, interview, and review of facility policy, the facility failed to perform hand hygiene and administer medications in a manner to prevent cross-contamination for 1 resident (R) (R6) of 2 residents observed during medication administration. This failure had the potential to spread of pathogens in the facility.</p> <p>Findings include:</p> <p>The facility's Handwashing/Hand Hygiene policy, dated 8/2014, indicates: .Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations .After removing gloves .Hand hygiene is the final step after removing and disposing of personal protective equipment .</p> <p>During an observation on 6/10/25 at 5:21 PM, Licensed Practical Nurse (LPN) 2 discarded a pair of gloves in the trash and immediately picked up a mouse on the medication cart and began to type on the computer. When asked if LPN 2 should have performed hand hygiene after discarding gloves, LPN 2 continued to chart and stated LPN 2 would after LPN 2 was done. When asked to provide LPN 2's name, LPN 2 indicated LPN 2 was an agency nurse and stated, I don't work here.</p> <p>During an observation and concurrent interview on 6/10/25 at 5:27 PM, LPN 2 retrieved a new Humalog KwikPen subcutaneous solution pen injector 100 unit/milliliter (ml) (insulin lispro) insulin pen from the medication cart. At 5:28 PM, LPN 2 accessed the insulin pen with a needle without first cleaning the pen's rubber septum. When asked the requirement for cleaning the pen hub before accessing it, LPN 2 stated it was a new pen and did not need to be cleaned. At 5:29 PM, LPN 2 administered four units of insulin to R6.</p> <p>During an interview on 6/10/25 at 6:43, Unit Manager (UM) 1 stated it is UM 1's expectation that staff sanitize their hands after removing gloves and clean an insulin pen's hub before accessing it with a needle, even if the pen is new.</p>		