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	08/20/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview and record review, the facility failed to prevent resident-to-resident abuse for 2 residents (R) (R8 and R4) of 13 sampled residents.On 7/6/25, R3 hit R8 in the face in the dining room.On 7/14/25, R2 held R4's arm down and punched R4 in the face and hand.Findings include:Review of the facility's Abuse, Neglect, and Exploitation policy, with a revised date of 1/5/24, revealed it was the facility's policy to provide protections for the health, welfare, and rights of each resident by developing and implementing policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property.1. A document titled Misconduct Incident Report, a State of Wisconsin Department of Health form signed by the Administrator, stated it was submitted to the State Agency (SA) on 7/11/25 at 3:21 PM. According to the report, on 7/6/25 at 9:30 AM, R3 was sitting in the dining room eating breakfast when the nurse noted R3 hit R8 in the face causing R8 to fall. R3 then became agitated and walked out of the dining room and stated R3 was going to walk out the door and did not care what anyone said. R3 was redirected and immediately removed from the incident. According to the report, R8 had severe advanced dementia. R8 was sent to the hospital, returned with no ill effects or injuries, ambulated through the unit per usual, and was redirectable. The Administrator, Director of Nursing (DON), police, and psychiatric services were notified. Review of R3's admission Record revealed R3 was admitted to the facility on [DATE]. R3's diagnoses included delusional disorder, mild neurocognitive disorder due to known physiological condition without behavioral disturbance, glaucoma, and insomnia.Review of R3's Annual Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 4/23/25, revealed R3 had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 indicating R3 had severe cognitive impairment. The MDS assessment stated R3 did not have any behaviors.Review of R3's plan of care revealed a care plan, with an initiation date of 6/18/25, that stated R3 used vulgar language and/or intimidation to express feelings toward other residents and staff. Interventions included to monitor status and psychosocial well-being, and offer R3 to go for a walk, listen to music, or watch television as a way to de-escalate. On 7/6/25, the following interventions were added: psychosocial assessment due to peer-to-peer for 72 hours, if reasonable, discuss R3's behavior and reinforce why the behavior is inappropriate and/or unacceptable, and determine and remove underlying cause. A progress note, dated 7/6/25 at 9:31 AM and written by Licensed Practical Nurse (LPN)2, stated R3 hit another resident in the face at 9:00 AM. The note stated R3 could be aggressive and had aggressive behavior before. R3 was currently agitated, pacing, and telling people not to touch R3. R3 was put on one-to-one supervision and monitored for increased behaviors. A progress note, dated 7/6/25 at 5:59 PM, stated R3 was being monitored one-to-one related to a physical altercation. R3 was verbally aggressive that shift and stated, Close my door so I don't have to hurt that man out there. Review of R8's admission Record revealed R8 was admitted to the facility on [DATE]. R8's diagnoses included dementia, insomnia, and anxiety.Review of R8's Quarterly MDS assessment, with an ARD of 6/5/25, revealed R8 had severely impaired cognitive skills. A progress note, dated 7/6/25 at 9:46 AM, stated R8 walked past another resident in the dining room who stood up from the table and hit R8 on the left side of the face which caused R8 to fall to the floor. R8 did not have any signs or symptoms of pain. The Nurse Practitioner (NP) was notified and R8 was sent to the emergency room (ER) for evaluation. A progress note, dated 7/6/25, stated R8 returned from the ER and had a computed tomography (CT) scan of the face and head with normal results. R8 did not appear in any pain/discomfort and there were new skin concerns. During a telephone interview with LPN2 on 8/18/25 at 5:07 PM, LPN2 stated LPN2 did not witness the incident but was in the dining room at the time of the altercation. LPN2 stated R8 walked to the dining room and R3 was sitting at a table. LPN2 heard R8 fall and hit R8's head. LPN2 stated R8 was sent to the hospital and returned the same day. LPN2 stated R8 walked up and down the halls all day and at times wandered into other residents' rooms. LPN2 indicated R8 did not go far into the rooms and then turned around and went back into the hall. LPN2 stated that was the only resident-to-resident altercation that LPN2 was aware of.On 8/19/25 at 4:03 PM, the DON verified R3 hit R8 which initiated a resident-to-resident incident report, dated 7/6/25. The DON stated because of the abuse, the facility put R3 on one-to-one observation until 7/7/25 when R3 was moved from the second floor to the first floor. The DON stated the residents on the first floor were more like R3. The DON stated staff did ongoing monitoring of R3's behaviors and educated R3 not to hit residents. The DON stated that was the first

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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** Based on staff interview, record review, and policy review, the facility failed to ensure an allegation of missing money was reported to the State Agency (SA) for 1 resident (R) (R10) of 3 sampled residents. R10 reported $650 was missing from a pill bottle in R10's dresser drawer. The allegation of misappropriation was not reported to the SA.Findings include:Review of the facility's policy titled Abuse, Neglect, and Exploitation, with a revised date of 1/5/24, revealed it is the facility's policy 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. Under the reporting/response section of the policy it states alleged violations will be reported to the required agencies no later than 24 hours if the events do not involve abuse.Review of a grievance form for R10, dated 6/25/25, revealed R10 stated when R10 came back from dialysis on 6/23/25, R10 realized $650 that R10 had in a pill bottle in R10's dresser drawer was missing. R10 also stated R10 was removed from the 600 unit because R10 had $3900 missing. According to the grievance form, R10's room was searched but the money was not found. The Actions Taken section stated there was no evidence that R10 had $650 and no evidence that R10 had money when R10 resided on the 600 unit. The risks and benefits of locking up valuables or sending them home with family were discussed. According to the grievance form, R10 changed the amount of money several times and did not know the denominations. R10 was informed the facility was not responsible for the missing money.During an interview on 8/20/25 at 9:39 AM, R10 stated R10 twice had missing money while residing in the facility, once while residing on the second floor and once while residing on the first floor. R10 stated R10 reported the missing money but nothing was done. An admission Record located in R10's electronic medical record (EMR) revealed R10 was admitted to the facility on [DATE]. R10's diagnoses included end stage renal disease, schizophrenia, and blindness of the left and right eye.Review of R10's Quarterly Minimum Data Set (MDS) assessment, with an assessment reference date of 5/16/24, revealed R10 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R10 had intact cognition. Review of R10's care plan, with an initiated date of 11/8/24, revealed R10 preferred to keep money on R10's person and declined the use of a lock box. The care plan contained an intervention, dated 6/24/5, to encourage R10 to keep money in a lockbox and continue to re-iterate the risks/benefits of using a lockbox for money and valuables or send them home with family and friends. R10's progress notes from 1/1/25 to the present did not refer to R10's complaint of missing money. During an interview with the Director of Nursing (DON) on 8/20/25 at 4:05 PM, the DON verified R10's allegation of missing money was not reported to the SA because there was no evidence that R10 ever had the money. The DON indicated R10 kept changing the amount of missing money and did not know the denominations of the missing money.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview, record review, and policy review, the facility failed to thoroughly investigate an allegation of missing money for 1 resident (R) (R10) of 3 sampled residents.R10 reported $650 was missing from a pill bottle in R10's dresser drawer. The allegation of misappropriation was not thoroughly investigated. Findings include:Review of the facility's policy titled Abuse, Neglect, and Exploitation, with a revised date of 1/5/24, revealed it is the facility's policy 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. Under the reporting/response section of the policy it states alleged violations will be reported to the required agencies no later than 24 hours if the events do not involve abuse.Review of a grievance form for R10, dated 6/25/25, revealed R10 stated when R10 came back from dialysis on 6/23/25, R10 realized $650 that R10 kept in a pill bottle in R10's dresser drawer was missing. R10 also stated R10 was removed from the 600 unit because R10 had $3900 missing. According to the report, R10's room was searched but the money was not found. The Actions Taken section stated there was no evidence that R10 had $650 and no evidence that R10 had money when R10 resided on the 600 unit. The risks and benefits related to locking up valuables or sending them home with family were discussed. According to the grievance form, R10 changed the amount of money several times and did not know the denominations. R10 was informed the facility was not responsible for the missing money.During an interview on 8/20/25 at 9:39 AM, R10 stated R10 twice had missing money while residing in the facility, once while residing on the second floor and once while residing on the first floor. R10 stated R10 reported the missing money but nothing was done. An admission Record located in R10's electronic medical record (EMR) revealed R10 was admitted to the facility on [DATE]. R10's diagnoses included end stage renal disease, schizophrenia, and blindness of the left and right eye.Review of R10's Quarterly Minimum Data Set (MDS) assessment, with an assessment reference date of 5/16/24, revealed R10 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R10 had intact cognition. Review of R10's care plan, with an initiated date of 11/8/24, revealed R10 preferred to keep money on R10's person and declined the use of a lock box. The care plan contained an intervention, dated 6/24/25, to encourage R10 to keep money in a lockbox and continue to re-iterate the risks/benefits of locking up valuables or send them home with family and friends. R10's progress notes from 1/1/25 to the present did not mention R10's complaint of missing money.During an interview with the Director of Nursing (DON) on 8/20/25 at 4:05 PM, the DON verified R10's allegation of missing money was not investigated because there was no evidence that R10 ever had the money. The DON also indicated R10 kept changing the amount of the missing money and did not know the denominations of the missing money.