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	12/30/2025

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. (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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, record review, and facility policy review, the facility failed to ensure resident council grievances were resolved in a timely manner for three out of six monthly meetings, by three council members/attendees of the resident council meetings (Resident (R) 29, R15, and R31) of 31 sample residents. Failure to address and resolve grievances raised during resident council meetings in a timely manner has the potential to negatively affect residents' quality of life and satisfaction with care.Findings include:1.Review of R29's electronic medical records (EMR) titled admission Record located under the Profile tab indicated the facility admitted the resident on 05/13/25.Review of R29's EMR titled annual Minimum Data Set (MDS) located under the MDS tab with an Assessment Reference Date (ARD) of 11/01/25 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which revealed the resident was cognitively intact.2. Review of R15's EMR titled admission Record located under the Profile tab indicated the facility admitted the resident on 11/25/24.Review of R15's EMR titled annual MDS located under the MDS tab with an ARD of 11/04/25 revealed the resident had a BIMS score of 15 out of 15 which revealed the resident was cognitively intact. 3. Review of R31's EMR titled admission Record located under the Profile tab indicated the facility admitted the resident on 12/01/17.Review of R31's EMR titled annual MDS located under the MDS tab with an ARD of 11/19/25 indicated the resident had a BIMS score of six out of 15 which revealed the resident was severely cognitively impaired. A review was conducted of documents provided by the facility titled Resident Council Meeting Minutes, dated 10/21/25, indicated the resident council members voiced that they would like feedback on all the administrative changes, requests were made for more puzzles, shopping trips out in the community, more fresh fruit, and vegetables, and voiced that there were times there were not enough snacks for the residents. The members of the resident council meeting voiced that they wanted more butter and syrup with the pancakes that were served during breakfast. Finally, the council attendees voiced that they would like to meet with dietary to discuss concerns with meals served. A review was conducted of documents provided by the facility titled Resident Council Meeting Minutes, dated 11/19/25, revealed the former Activity Director informed the resident council attendees that there was a new Administrator but failed to ensure the attendees were informed of any resolution from the previous Resident Council Meeting. The meeting minutes failed to have a section in the document which addressed current Resident Council Members' concerns for the month. A review was conducted of documents provided by the facility titled Resident Council Meeting Minutes, dated 12/18/25, indicated the resident council attendees were not provided resolution from 10/21/25 issues. Specifically, the council attendees voiced the same concerns identified in 10/21/25 with no resolution.During an interview conducted on 12/29/25 at 4:37 PM, the facility's Concierge stated she was responsible for addressing resident grievances. The Concierge stated she had not been invited to any resident council meetings from 08/25 through 11/25. The Concierge stated she was recently invited to the resident council meeting for the month of 12/25, and she was invited by the President of Resident Council (R15). During an interview conducted on 12/30/25 at 8:35 AM, R15 confirmed she was the President of the Resident Council. R15 stated that there had been multiple complaints filed by the members and attendees of the resident council meeting and there had been no follow-up by the facility. R15 stated this was extremely frustrating to see the same issues unaddressed from month to month with no resolution. During an interview on 12/30/25 at 9:45 AM, R29 was only able to answer yes/no questions by shaking her head. R29 confirmed there were issues identified at each resident council meeting such as complaints about food and there had been no follow-up made by the facility. During an interview on 12/30/25 at 11:43 AM, R31 confirmed she attended the Resident Council Meetings and verified that there had been complaints formulated and no follow-up was made by the facility. During an interview on 12/29/25 at 3:14 PM, the Regional Nurse stated all grievances were to be resolved.Review of a facility's policy titled, Resident Council, dated 12/06, indicated .The facility supports residents' desire to be involved in and have input in the operation of the facility though the Resident Council. Minutes include names of the council members, and any guests present; issues discussed; recommendations from the council to the Administrator; and follow-up on prior issues.The Administrator reviews the minutes and any responses from departments within the facility. Responses are presented at the next meeting, or sooner, if indicated.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure a clean and homelike environment was maintained for eight of 31 sample residents (Resident (R) 20, R28, R14, R15, R18, R19, R16, and R17) reviewed for the environment. This had the potential to affect residents' well-being throughout the facility by not having a clean and homelike environment. Findings include:1. Review of R20's electronic medical record (EMR) titled admission Record located under the Profile tab indicated the facility admitted the resident to the facility on [DATE].Review of R20's EMR titled quarterly Minimum Data Set (MDS) located under the MDS tab with an Assessment Reference Date (ARD) of 10/07/25 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which revealed the resident was moderately cognitively impaired.2. Review of R28's EMR titled admission Record located under the Profile tab indicated the facility admitted the resident to the facility on [DATE].Review of R28's EMR titled quarterly MDS located under the MDS tab with an ARD of 09/12/25 indicated the resident had a BIMS score of 12 out of 15 which revealed the resident was moderately cognitively impaired. 3. Review of R14's EMR titled admission Record located under the Profile tab indicated the facility admitted the resident to the facility on [DATE].Review of R14's EMR titled admission MDS located under the MDS tab with an ARD of 10/29/25 indicated the resident had a BIMS score of 13 out of 15 which revealed the resident was cognitively intact.4. Review of R15's EMR titled admission Record located under the Profile tab indicated the facility admitted the resident to the facility on [DATE]. Review of R15's EMR titled annual MDS located under the MDS tab with an ARD of 11/04/25 indicated the resident had a BIMS score of 15 out of 15 which revealed the resident was cognitively intact. 5. Review of R18's EMR titled admission Record located under the Profile tab indicated the facility admitted the resident to the facility on [DATE]. Review of R18's EMR titled admission MDS located under the MDS tab with an ARD of 10/29/25 indicated the resident had a BIMS score of nine out of 15 which revealed the resident was moderately cognitively impaired. 6. Review of R19's EMR titled admission Record located under the Profile tab indicated the facility admitted the resident on 06/11/25.Review of R19's EMR titled quarterly MDS located under the MDS tab with an ARD of 12/03/25 indicated the resident had a BIMS score of seven out of 15 which revealed the resident was severely cognitively impaired. 7. Review of R16's EMR titled admission Record located under the Profile tab indicated the facility admitted the resident on 08/06/24. Review of R16's EMR titled quarterly MDS located under the MDS tab with an ARD of 11/12/25 indicated the resident had a BIMS score of 10 out of 15 which revealed the resident was moderately cognitively impaired. 8. Review of R17's EMR titled admission Record located under the Profile tab indicated the facility admitted the resident on 07/23/25. Review of R17's EMR titled quarterly MDS located under the MDS tab with an ARD of 11/10/25 revealed the staff could not determine the resident's BIMS score. During observations and interview conducted on 12/29/25 at 11:55 AM, R20 permitted the surveyor to open the [NAME] and [NAME] bathroom (a bathroom with entry from two different resident rooms with a shared bathroom space for use). There was a used urinal and a container of soiled clothing in a plastic hamper. The hamper was uncovered and there was a strong smell of urine. A general tour was conducted of the resident's room. There was a thick layer of dark dust on the top of her wall heater. The window shelf adjacent to the resident's bed was covered with dark dust as well. The sink in the room had a broken drain plug. The room next to R20 was observed. R28 stated that the staff never moved her bed to clean underneath it. The window shelf, adjacent to her bed had a thick layer of dust and a cobweb. There were candy wrappers on the side of the resident's bed. The wall heater had dust on the top of it. The floor around the resident's bed was sticky. The floorboard at the head of the resident's bed was coming off the wall. The room for R14 and R15 was observed. The ceiling above R14's bed had a large splatter on it. The window adjacent to R15 had a towel in front of the base of the window. There were visible splash marks on the wall in which the television of R15 was mounted. On the wall adjacent to R14's bed were large scrapes. There were no patching and no paint in this area. R15 confirmed that the staff did not repair the walls in the residents' room. There was a broken sink plug in R14 and R15s' room. The baseboard across from R14's bed had two thick brown stains that could not be wiped off. The room for R16 and R17 was observed. There were deep scratches on the wall adjacent to R17. The ceiling above R17 had brown stains. The bed extenders for R17 had brown and yellow dried material on them. The attached closet in the room had exposed pressed wood from under the closet. A tour was conducted on 12/29/25 at 12:20 PM with the Regional Manager for (name of contracted housekeeping

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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. Based on record review, interview, and facility policy review, the facility failed to ensure one of four residents (Resident (R) 6) reviewed for abuse/neglect was protected from physical abuse by R7 of 31 sample residents. (Cross Reference F610)On 11/22/25 R7 was found by Certified Nursing Assistant (CNA)9 to be hitting R6 in the chest. R7 and R6 were roommates at the time. A reasonable person would not expect to be hit by their roommate in their own room/living space.Findings include:1. Review of R6's electronic medical record (EMR) titled admission Record located under the Profile' tab indicated the facility admitted the resident on 08/05/22.Review of R6's EMR titled Care Plan located under the Care Plan tab, dated 08/05/22, indicated the resident had limited physical mobility related to general weakness, Parkinson's disease, traumatic brain injury, and hemiplegia (paralysis affecting one side of the body). Review of R6's EMR titled nursing Progress Notes located under the Prog (Progress) Notes tab, dated 11/22/25, indicated Certified Nurse Aide (CNA) 9 observed R7 hitting the chest of R6. CNA9 reported she immediately removed R7 from the resident-to-resident incident. 2. Review of R7's EMR titled admission Record located under the Profile tab indicated the facility admitted the resident on 02/08/23. Review of R7's EMR titled Care Plan located under the Care Plan tab, dated 01/26/25, indicated that the resident had altered activities of daily living related to mobility impairment, hemiplegia, and cognitive impairment. Review of a document provided by the facility titled Misconduct Incident Report, dated 11/22/25, indicated that CNA9 heard R6 yelling out and went to his room. CNA9 found R7 hitting R6 in the chest. R7 stated I can't take it anymore. The residents' responsible parties were notified of the resident-to-resident incident, and the police were called. There was evidence that the facility reported the resident-to-resident incident to the State Survey Agency (SSA) timely. Review of a document provided by the facility titled .Summary., dated 12/01/25, revealed R6 had a recent Brief Interview for Mental Status (BIMS) score of three out of 15 which revealed the resident was severely cognitively impaired. The document indicated that R7 had a recent BIMS score of 10 which revealed that the resident was moderately cognitively impaired. Both residents were unable to state what precipitated the resident-to-resident incident. In addition, R6 did not sustain any injuries and was moved to a private room. There was evidence that the facility reported the five-day summary to the SSA timely. During an interview on 12/29/25 at 9:17 AM, R6 stated he felt safe living at the facility and did not remember hitting another resident. During an interview on 12/29/25 at 9:53 AM, R7 stated he felt safe living at the facility and the resident did not remember being hit by another resident. During an interview on 12/30/25 at 8:22 AM, CNA9 confirmed she was the staff member who observed R7 hitting R6 in the chest. CNA9 confirmed she immediately removed R6 from R7 and reported the resident-to-resident incident. During an interview on 12/30/25 at 9:03 AM, the Administrator stated that whenever there was a resident-to-resident incident they wanted to make sure if the situation was isolated or not. The Administrator confirmed that both R6 and R7's responsible parties were notified and the police. The Administrator stated both residents failed to have any insight during the incident. Review of a facility's policy titled, Abuse, Neglect and Exploitation, dated 01/05/24, indicated .It is the policy of this facility to provide protection 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.'Abuse' means the willful inflection injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.

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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. Based on record review, interview, and facility policy review, the facility failed to ensure one of four residents (Resident (R) 6) reviewed for abuse/neglect was protected from physical abuse by R7 of 31 sample residents. This had the potential to cause emotional and/or physical harm. Findings include:1. Review of R6's electronic medical record (EMR) titled admission Record located under the Profile' tab indicated the facility admitted the resident on 08/05/22.2. Review of R7's EMR titled admission Record located under the Profile tab indicated the facility admitted the resident on 02/08/23. Review of a document provided by the facility titled Misconduct Incident Report, dated 11/22/25, indicated that Certified Nurse Aide (CNA) 9 heard R6 yelling out and went to his room. CNA9 found R7 hitting R6 in the chest. R7 stated I can't take it anymore. CNA9 separated the two residents. R6 was assessed for injuries and there were none. The investigation included a written statement by CNA9 and an attempt to interview R6 and R7. The investigation failed to include interviews with other staff and residents around the location of R6 and R7's room to rule out other instances of resident-to-resident abuse.During an interview on 12/29/25 at 3:14 PM, the Regional Nurse stated that it was important to interview other staff and residents, even if it was an isolated incident to rule out abuse. During an interview on 12/30/25 at 9:03 AM, the Administrator stated the resident-to-resident incident included the immediate separation of R6 and R7. The Administrator stated R6 was assigned a new room. The Administrator confirmed CNA9 was the only person interviewed since the staff member witnessed the resident-to-resident and it was an isolated event.Review of a facility's policy titled, Abuse, Neglect and Exploitation, dated 01/05/24, indicated .Investigation of Alleged Abuse.An immediate investigation is warranted when allegation or suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect or exploitation occur.Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegation(s).