STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525085	A. Building B. Wing	07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eastcastle Pl Bradford Ter Conv Ctr	2505 E Bradford Ave Milwaukee, WI 53211

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 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. (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 0609 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 interview and record review, the facility did not ensure 1 (R1) of 1 facility reported incidents reviewed for an allegation of misappropriation, was reported to the local law enforcement agency.*On 6/26/25, facility staff was made aware of R1's missing narcotic pain medication. The facility did not report the incident to local law enforcement.Findings include: The facility policy with a revision date of November 2022, titled Controlled Substances documents, in part: . Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services. The director of nursing services documents irreconcilable discrepancies in a report to the administrator. If a major discrepancy or a pattern of discrepancies occurs, or if there is apparent criminal activity, the director of nursing notifies the administrator and consultant pharmacist immediately. The administrator, consultant pharmacist and/or director of nursing services determine whether other action(s) are needed, e.g., notification of police or other enforcement personnel. The facility policy dated 9/22/23 titled Abuse Prevention Program documents, in part: . Employees are required to report any incident, allegation, or suspicion of potential abuse neglect or misappropriation of property they observe, hear about, or suspect immediately to the Administrator or the person in charge of the community, acting on behalf of the Administrator. If a crime is suspected, the Administrator will coordinate timely reporting to the state survey agency and local law enforcement on behalf of the employees involved. Any incident or allegation involving abuse, neglect, or misappropriation will result in an abuse investigation. If a reasonable suspicion of a crime has occurred, the resident's representative and the Department of Health and law enforcement shall be informed according to the following timeframes: Serious bodily injury- immediately but not later than 2 hours after forming the suspicion. All others- not later than 2 hours after forming the suspicion.R1 was admitted to the facility on [DATE]. R1 is currently on hospice care and has the following active MD order: Morphine Sulfate (Concentrate) Oral Solution 100 [milligrams (mg) per 5 milliliters (ml)]. Give 0.25 ml by mouth every 4 hours as needed for Pain - Moderate to severe pain.Surveyor reviewed the facility self-report regarding R1's Morphine medication. The self-report documents, in part: During narcotic count PM shift change on June 26, 2025, our two-nurse counting protocol identified an isolated discrepancy with [R1]'s morphine syringe bags. The two nurses counting were present. The physical count did not align with the documented record, resulting in a numerical variance from 19 vs. 20 syringes. Investigation initiated, and a comprehensive search of the designated medication storage and transport areas was performed. Nurse Educator contacted all relevant nursing staff who had been on duty since the discrepancy was identified. [R1] is on hospice services, who were also spoken to and did not administer. Pharmacy also contacted and confirmed that the 20 syringes were delivered on the refill on 6/25. The investigation concluded that there was no evidence of diversion or intentional misappropriation as the singular 0.25morphine syringe was not found through investigation and search. The self-report includes: all staff interviews and statements completed, the conclusion of the audits of medication carts, the pharmacy packing slip indicating the amount of Morphine delivered on 6/25/25, review of R1's Medication Administration record, Narcotic sheets and pain assessments, and Education provided to nursing staff. On 7/15/25 at 12:51 PM, Surveyor interviewed Registered Nurse (RN)-E who worked the night shift starting on 6/25/25 and went to the morning of 6/26/25. Surveyor asked what occurred on 6/25/25 through 6/26/25 regarding R1's Morphine medication. RN-E stated that on the evening of 6/25/25 RN-E received a delivery of R1's Morphine from the pharmacy. RN-E stated that RN-E took the bag of Morphine and counted the number of syringes twice to ensure the count was correct. RN-E stated that Licensed Practical Nurse (LPN)-C was witness to the count completed. RN-E stated there was 20 syringes. RN-E put the medication in the med drawer and locked the drawer. RN-E did not give any Morphine during that shift. RN-E stated that R1 was comfortable and did not display any signs or symptoms of pain during that shift. At the end of RN-E's shift, RN-E completed the narcotic count with LPN-D and the count remained at 20 syringes.On 7/15/25 at 12:46 PM, Surveyor interviewed LPN-C who worked the PM shift on 6/25/25 and the PM shift on 6/26/25. Surveyor asked what occurred on 6/25/25 through 6/26/25 regarding R1's Morphine medication. LPN-C stated that LPN-C witnessed the counting of R1's Morphine on 6/25/25 after it was delivered by pharmacy. LPN-C stated that RN-E counted the medication and got a count of 20. The next day when LPN-C returned to the facility for LPN-C's next shift