STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020776	A. BUILDING: _____ B. WING _____	C 10/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZURA MEMORY CARE AND ASSISTED LIVING OF VI	285 WILDCAT WAY VERONA, WI 53593

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 10/07/2026, Surveyor conducted a complaint investigation at Azura Memory Care and Assisted Living of Verona, a CBRF in Verona. One deficiency was identified. The complaint was substantiated. Census: 79	N 000		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the legal representative for 1 of 2 residents reviewed was notified when the resident sustained falls. Resident 1's Health Care Power of Attorney was not notified of 5 falls from 06/24/2026 to 09/25/2026. Findings include: On 10/07/2026, Surveyor completed a complaint investigation alleging the provider did not notify	N 169		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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N 169	Continued From page 1 necessary parties of falls. On 10/07/2026 at approximately 10:00 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 01/08/2025. Resident 1's individual service plan (ISP), last revised 07/17/2026, indicated Resident 1 had an activated Health Care Power of Attorney and was at risk for falls. Resident 1's progress notes, dated 06/01/2026 to 10/07/2026, documented the following falls without documentation that the Health Care Power of Attorney was updated regarding the fall: - 06/24/2026 (for the date of 06/22): "Resident was combative throughout the evening. Before bedtime [Resident 1]'s alarm went off so I went to check on [him/her]. Resident was on the floor and appeared to be okay. Resident was alert and wasn't showing any signs of discomfort." - 07/12/2026: "Writer watched resident out of chair and misstep. Resident slid to the floor and did not hit head. Writer asked resident if [s/he] was ok and resident stated that [s/he] was fine. Writer assisted resident to get back into chair and notified [Assistant Executive Director." - 07/31/2026: "Resident was found on the floor around 2:45 a.m. Resident slid [sic] out of bed trying to get back into bed after using the bathroom. Resident was stable and got back into bed with no problems. Resident complained about some arm pain from a previous fall writer gave a prn and resident went back to sleep." - 08/02/2026: "Resident had an unwitnessed fall in the hallway outside of [his/her] room. Resident said [s/he] felt fine and nothing hurts." - 09/25/2026: "Resident had a fall today at breakfast. Resident was trying to stand up and grab some creamer for [his/her] coffee. Care staff helped resident off the floor and got [him/her]	N 169		

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N 169	Continued From page 2 back to [his/her] wheelchair. Resident is stable. Resident is currently sitting on couch in the living room. RN and [Executive Director] is notified of fall." On 10/07/2026 at approximately 11:00 a.m., Surveyor interviewed Executive Director A and Regional Director B regarding notifications of falls. Surveyor reviewed the above dates when notification of falls was not documented. Regional Director B stated s/he would need to review notes and that some notifications may be documented in incident reports, which would not be provided to Surveyor because they were internal quality assurance documents. On 10/07/2026 at approximately 11:30 a.m., Executive Director A followed up with Surveyor and provided documentation of incident reports. The incident reports provided did not correlate with the 06/22/2026, 07/12/2026,07/31/2026, 08/02/2025 and 09/25/2026 falls. Executive Director A stated there was not an incident report completed for each fall. Executive Director A stated caregivers may not have considered a slide to the ground as a fall, but it would be a fall and notifications should have taken place. Executive Director A stated the provider would need to complete caregiver education regarding fall procedures.	N 169		