STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018260	A. BUILDING: _____ B. WING _____	C 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZURA AT MIEROW FARM BROOKFIELD BUILDING E	16030 WASHINGTON DRIVE BROOKFIELD, WI 53005

(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 08/19/2025, the Bureau of Assisted Living, Southern Regional Office conducted a complaint investigation at Azura At Mierow Farm Brookfield Building B - Elmbrook, located at 16030 Washington Drive in Brookfield, WI. One citation of noncompliance was issued. The complaint was substantiated. Census: 20	N 000		
N 382	83.35(1)(b) Sources used for assessment information. Information gathering. The CBRF shall base the assessment on the current diagnostic, medical and social history obtained from the person ' s health care providers, case manager and other service providers. Other service providers may include a psychiatrist, psychologist, licensed therapist, counselor, occupational therapist, physical therapist, pharmacist or registered nurse. The administrator or designee shall hold a face-to-face interview with the person and the person ' s legal representative, if any, and family members, as appropriate, to determine what the person views as his or her needs, abilities, interests, and expectations. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure a face-to-face interview with Resident 1 and Resident 1's legal representative was conducted to determine what Resident 1 viewed as his/her needs, abilities, interests, and expectations prior to Resident 1's admission to the facility.	N 382		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 382	Continued From page 1 On 04/22/2025, the facility conducted a virtual pre-admission interview/assessment with Resident 1 via the video conferencing platform Zoom. Resident 1 was residing in New York state at the time of the pre-admission interview/assessment. During this virtual pre-admission interview/assessment, Resident 1 repeatedly asked why the interview was being conducted and significant behavioral issues/concerns were not identified. Following Resident 1's admission to the facility on 05/22/2025, Resident 1 exhibited significant behavioral challenges before being hospitalized within 24 hours of Resident 1's physical admission to the facility. The findings are: On 08/19/2025 at 9:22 A.M., Administrator A told Surveyor Resident 1 was contractually admitted to the facility on 04/30/2025 following a virtual, pre-admission assessment conducted by Facility Nurse C and Director of Community Relations D via the video conferencing platform Zoom. Administrator A said Resident 1 lived in New York state at the time of the virtual pre-admission assessment. Administrator A told Surveyor the facility had received a New York state health proxy identifying Family Member F as Resident 1's power of attorney (POA) for healthcare, but the facility did not believe it had been activated. Administrator A said Resident 1's Family Member E signed Resident 1's admission agreement prior to Resident 1's physical admission to the facility, despite the facility not having documentation including Family Member E as Resident 1's legal representative. Administrator A said Resident 1 was physically admitted to the facility on 05/22/2025 with diagnoses including dementia immediately following a flight from New York state	N 382		

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N 382	Continued From page 2	N 382		

with Resident 1's Family Member F.
Administrator A said both Family Members E and F were present at the facility when Resident 1 was admitted to the facility. Administrator A said Family Member E did not have knowledge of Resident 1's behavioral care needs at the time of Resident 1's arrival at the facility on 05/22/2025. Administrator A said it appeared as though Family Member E and Family Member F exhibited poor communication with each other.
Administrator A told Surveyor Facility Nurse C attempted to assess Resident 1 face-to-face after Resident 1's arrival at the facility but was unable to conduct a complete assessment related to Resident 1's behavior including extreme agitation. Administrator A told Surveyor Resident 1 was transported to a local hospital on 05/23/2025 within 24 hours of Resident 1's arrival at the facility related to Resident 1's behavior. Administrator A said s/he was informed by hospital staff Resident 1 required physical and chemical restraints, a one-to-one 'sitter,' and continued to refuse medication administration after being hospitalized for 1 week. Administrator A told Surveyor Resident 1 did not return to the facility following hospitalization and was officially discharged from the facility on 06/05/2025.

On 08/19/2025, Surveyor and Facility Nurse C reviewed Resident 1's assessment conducted prior to Resident 1's admission to the facility, Resident 1's pre-admission documentation, and Resident 1's New York state health proxy documentation, as requested from Administrator A.
Resident 1's pre-admission agreement documentation completed by Facility Nurse C on 04/22/2025 included Resident 1's diagnoses including "dementia." The documentation included, "Why are they [Resident 1] looking to

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N 382	Continued From page 3	N 382		

move to [facility]: Memory." The documentation included Resident 1 required assistance with medication management, including as needed medication related to "arthritis." The documentation included Resident 1 required assistance with "bathing [and] showering" related to "Sponge bath, more than shower. [Resident 1] does not like water on [his/her] face." The documentation included Resident 1 "can have accident at times" related to bladder and bowel incontinence. The documentation included Resident 1 required assistance with "dressing [and] undressing" related to "ensure wearing proper clothing." The documentation included Resident 1 was "capable of independent decision making" and behaviors including "unable to follow directions - due to wanting to do things [s/he] wants." The documentation included Resident 1 required assistance with "behavior management" and "reluctance to accept care." The documentation included Resident 1 "refused shower - POA aware" and "fear of water." The documentation included Resident 1 would "look for people, places, or things (former house/apartment/bus)" related to "safety [and] risk." The documentation included, "[Resident 1] needs refocusing for anxious, agitated, disruptive, or exploring characteristics (> [more than] 3x [times] / [per] day, may require frequent PRN [as needed] psychotropic administration. May have verbal aggression such as yelling, physical aggression, inappropriate sexual expressions, inappropriate elimination, attempts at elopement. May require 30 minute checks and/or periodic periods of individual supervision."

At approximately 10:41 A.M., Facility Nurse C told Surveyor s/he conducted Resident 1's virtual pre-admission assessment with Director of Community Relations D on 04/22/2025. Facility Nurse C said s/he believed Resident 1 was

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N 382	Continued From page 4	N 382		

located within Resident 1's home in New York state during the virtual assessment. Facility Nurse C said s/he could visualize Resident 1 on the screen and believed Resident 1's Family Member F was also present with Resident 1 because s/he could here Family Member F provide some answers to his/her questions but did not see Family Member F on the screen.
Facility Nurse C said s/he thought Family Member F was Resident 1's POA or legal representative because Family Member F was with Resident 1 during the virtual assessment.
Facility Nurse C said s/he did not remember if s/he asked if Resident 1 had a POA/legal representative or if Family Member F was Resident 1's POA/legal representative as s/he had not documented this information within the assessment. Facility Nurse C told Surveyor Family Member F said Resident 1's memory "was slipping" and had diagnoses including dementia.
Facility Nurse C said Resident 1 was calm and cooperative throughout the virtual assessment which lasted approximately 30 to 45 minutes, but Resident 1 frequently asked "why [Facility Nurse C] was doing this [conducting the virtual interview/assessment]?"
Facility Nurse C said s/he did not ask Family Member F to specify Resident 1's behavior when attempting to assist Resident 1 with bathing, other than Resident 1 would refuse assistance, and Resident 1's response to being asked to do certain things s/he did not want to do. Facility Nurse C said Family Member F told him/her Resident 1 exhibited anxiety but was not specific and did not communicate Resident 1 exhibited agitated or aggressive behavior.
Facility Nurse C told Surveyor the facility received Resident 1's "Physician Plan of Care and Health History and Physical" and "Health Care Proxy" via fax on 05/05/2025, as documented on all of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 382	Continued From page 5	N 382		

documents. Resident 1's primary diagnoses included "Dementia" within the documentation. The documentation included "Staff will administer all medications," as signed on 04/22/2025.
Facility Nurse C told Surveyor the facility did not receive a list or orders for Resident 1's current, prescribed medications prior to Resident 1's admission on 05/22/2025. Resident 1's health care proxy dated as signed by Resident 1 on 07/13/2021 included, "{2} Optional: Alternate Agent. If the person I [Resident 1] appoint is unable, unwilling, or unavailable to act as my health care agent. I hereby appoint [Family Member F] as my health care agent to make any and all health care decisions for me, expect to the extent that I state otherwise." This health care proxy did not include Family Member E's name.

On 08/19/2025, Surveyor received Resident 1's admission agreement, Resident 1's visiting physician services enrollment form, Resident 1's demographic information, Resident 1's progress/caregiver notes as requested from Administrator A, and Resident 1's additional New York POA documentation.
Resident 1's admission agreement included, "This residency agreement is entered into as of 04/30/2025 by and between [Director of Community Relations D] and [Resident 1] and ("Responsible Party") for residency and services at [the facility]." The document was electronically signed by Accounting Director G and Family Member E on 04/29/2025.
Resident 1's visiting physician services enrollment documentation dated and signed by Family Member E on 05/02/2025.
Resident 1's demographic information included Resident 1's "original" admission date of 04/30/2025 and Resident 1's Family Member E listed as Resident 1's legal representative.

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N 382	Continued From page 6 Resident 1's progress/caregiver notes between 05/22/2025 through 06/11/2025 included: * 05/22/2025 at 2:56 P.M. a progress note included, "Admission/Move-In note. Late entry note text: At this time [Resident 1] arrived with POA and [Resident 1's] other [offspring]. [Resident 1] is exit seeking and upset. [Resident 1] is yelling and banging on doors, does not wish to stay at the community. Care team [House Manager B, Facility Nurse C, and "POA"] are all working to help [Resident 1] cope with new change." * 05/22/2025 at 3:00 P.M. a progress note included, "Late entry note text: At this time, care plan [ISP] reviewed, signed, and up loaded." * 05/22/2025 at 3:19 P.M. a progress note included, "Note text: At this time, [Resident 1] arrived with POA/family. Noted visibly upset and stated, "I [Resident 1] don't [sic] want to be here." Refused to get assessed and refused to be oriented to room or community. Talked with POA and at this time would give [Resident 1] some space and try to assess tomorrow to see if [s/he] would calm down and settle down. Care team will continue to monitor." * 05/22/2025 at 3:40 P.M. a progress note included, "Late entry current concern summary: Spoke with POA to confirm current medications. Per POA and [Resident 1's offspring], [Resident 1] is often non-compliant with taking [his/her] medication and it is difficult for them to get [Resident 1] to take them consistently. [Resident 1's offspring] also has additional medications that were brought from home; however, [s/he] has chosen to hold off on sending the medication list to [pharmacy] at this time. The medications are currently in the home and can be repackaged if needed or when [Resident 1] is ready to take them. [Resident 1] allowed [Facility Nurse C] to assess [his/her] lungs, which were clear to	N 382		

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	0018260	A. BUILDING: _____ B. WING _____	C 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZURA AT MIEROW FARM BROOKFIELD BUILDING E	16030 WASHINGTON DRIVE BROOKFIELD, WI 53005

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N 382	Continued From page 7	N 382		

auscultation. Abdomen was non-tender, non-distended, with active bowel sounds. [Resident 1] refused blood pressure, oxygen saturation, and temperature assessments due to increased agitation. Will continue to give [Resident 1] space and allow [him/her] time to settle in."
* 05/22/2025 at 10:39 P.M. a progress note included, "Note text: [Resident 1] did not have a good day. [Resident 1] was verbally abusive to residents and verbally and physically abusive to staff. [Resident 1] hit caregiver on arm and back with house phone, [Resident 1] also hit another caregiver in the head with one of [his/her] shoes. [Resident 1] was unable to be redirected. When hitting caregiver didn't [sic] work, [Resident 1] proceeded to break things in the home such as a dinner plate and throw things all around on the floor while screaming racial slurs towards caregivers."
* 05/23/2025 at 9:14 A.M. a progress note included, "Current Concern Summary: This morning attempted to assess [Resident 1]. Noted agitation. Trying to leave building. When asked what was wrong, [Resident 1] did not want to talk. As [Facility Nurse C] was observing [him/her], [s/he] attempted to break window to try and get out of the building. [Resident 1] is not aware of place, time. Only to [self]. Very agitated. Care team reported getting hit, throwing objects, scratching, trying to bite. No [sic] re-directable at this time. No medication available and refusing to take or eat anything. As [Facility Nurse C] was trying to talk with [him/her] and calm [him/her] down, [Resident 1] grabbed [Facility Nurse C's] hair and pulled it. Scratched [Facility Nurse C's] hand. Advised POA to take [Resident 1] to hospital to get evaluated and medicated. At this time, care team and writer are not able to complete a full assessment. POA in agreement."

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N 382	Continued From page 8 At 1:28 P.M., Administrator A and Facility Nurse C told Surveyor they believed Resident 1 was transported to the hospital via ambulance on 05/23/2025 at approximately 9:30 A.M. after 911 was called related to Resident 1's continued behavioral response following admission to the facility the previous day. * 05/24/2025 at 10:00 A.M. a progress note included, "[Activities Director H] was in communication with [Family Member E] on Saturday May 24 [05/24/2025] to check in to see how [Resident 1] is doing [and] if [Activities Director H] could provide any support to [Family Member E] during the difficult time with [Resident 1] being in the hospital. [Family Member E] advised [Activities Director H] that things were not good at the hospital. [Family Member E] stated that it took 5 nurses [and] 3 police officers to restrain [Resident 1] so they could administer Haldol [a psychotropic medication] for [his/her] behavior. [Family Member E] also advised that [Resident 1] attend [sic] suicide 2x [twice], 1 with doctor or nurse in the room. [Family Member E] stated [Resident 1] tried to suffocate [self] with a pillow from [his/her] hospital bed. While it was just [Family Member E] and [Resident 1] in the room at the hospital, [Resident 1] threatened to break the window so [s/he] could jump out of it [and] just die." * 05/25/2025 at 6:39 P.M. a progress note included, "Note text: At this time [House Manager B] spoke with POA and received not so good news. [Resident 1] now needs to see a cardiologist, neurologist, and geriatric specialist for the [dementia]. [Resident 1] has some heart rhythm issues that are significant and [Resident 1] needs to be on a monitor. [Resident 1] has severe sleep apnea which is causing blood oxygen to be very low. [Resident 1] has been restrained a total of five times today due to	N 382		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 382	Continued From page 9	N 382		

extreme expressions and now has bruising all over body. [Resident 1] also hurt [his/her] shoulder due to struggling with hospital staff. [Resident 1] is heavily sedated at this time." Administrator A provided Surveyor with a copy of a different New York health care proxy for Resident 1 than received by the facility on 05/05/2025. This proxy included Resident 1's name, but no date was included with Resident 1's signature. The documentation included, "(1) [Resident 1] hereby appoint [Family Member F] as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions. (2) Optional: Alternate Agent. If the person I [Resident 1] appoint is unable, unwilling, or unavailable to act as my health care agent. I hereby appoint [Family Member E] as my health care agent to make any and all health care decisions for me, expect to the extent that I state otherwise." This health care proxy was signed by 2 witnesses on 04/04/2025. Administrator A told Surveyor s/he received this document in the mail from Family Member E but the envelope did not include a date of receipt. Administrator A said s/he received the documentation after Resident 1 was discharged from the facility as part of Family Member E's and Family Member F's petition for temporary guardianship, permanent guardianship, and protective placement of Resident 1.

On 08/19/2025 at 1:28 P.M., Administrator A told Surveyor knowledge that the facility did not have appropriate documentation regarding Resident 1's POA was realized "after the fact." Administrator A said facility management conducted an audit of this facility and the other 3 associated licensed facilities on the campus to

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N 382	Continued From page 10 ensure all residents had appropriate POA documentation available or ensure residents capable of making decisions on their own behalf are given the opportunity to sign their own admission agreements and other documentation. Administrator A said the facility had not submitted a waiver to the department regarding conducting pre-admission interviews/assessments virtually instead of face-to-face as required. Administrator A said this practice was rare and the facility management re-evaluated their pre-admission interview/assessment practices following this incident.	N 382		