STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018262	A. BUILDING: _____ B. WING _____	C 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZURA MEMORY CARE OF FOX POINT	**7770 NORTH PORT WASHINGTON RD FOX POINT, WI 53217**

(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 02/14/2025, Surveyor completed a complaint investigation at Azura Memory Care of Fox Point As a result 1 complaint was substantiated. One deficient practice was identified. Census: 69	N 000		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident (Resident 1) received adequate and appropriate care within the capacity of the facility. Resident 1 had a cough for approximately one month, began to display weakness requiring a wheelchair for ambulation, did not want to eat, and exhibited left side face drooping and a puffy left eye. The	Y3244		

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

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Y3244	Continued From page 1 provider did not follow up on a STAT (urgent) x-ray order, and results indicated Resident 1 had pneumonia. Resident 1 passed away prior to receiving the diagnosis of pneumonia. Findings include: On 02/03/2025, the department received a complaint alleging concerns regarding same day request for medical attention was delayed until the next day. On 02/11/2025, at 9:00 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted to Azura Memory Care of Fox Point on 01/31/2024. Resident 1's diagnoses included gastro-esophageal reflux disease without esophagitis, constipation, irritable bowel syndrome, Raynaud's Syndrome, generalized anxiety disorder, presence of cardiac pacemaker, hypothyroidism, idiopathic peripheral autonomic neuropathy, Osteoarthritis, major depressive disorder, spinal stenosis, lumbar region with neurogenic claudication, necrotizing enterocolitis, headache syndromes, and myalgia. Resident 1's ISP, dated 01/31/2024, identified Resident 1 to be independent with transfers in and out of bed and chairs without assistance. Resident 1 dressed and undressed with minimal assistance, was independent with toileting activities, independent with feeding; however, at times required encouragement to eat. Resident 1 was independent with ambulation and toileting. -Progress note, dated 01/10/2025, indicated Resident 1 attended a psychiatry appointment due to concerns for increased confusion, self-isolation, physical decline, restlessness and poor appetite.	Y3244		

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Y3244	Continued From page 2	Y3244		

-Progress note, dated 01/26/2025, indicated the Power of Attorney B (POA B) requested Resident 1 to be seen by a nurse on Monday morning (01/27/2025) due to Resident 1's cough that lasted for approximately 1 month and indicated the cough did not seem to get better. There was no information related to whether Resident 1 was seen by the nurse on 01/27/2025.

-Progress note, dated 01/27/2025, indicated a caregiver observed Resident 1 to have a left puffy eye with a red streak going down the side of his/her face in addition to the left side of his/her mouth drooping. Resident 1 was described to eat 25 percent of his/her food. The nurse was notified of Resident 1's condition. There was no information related to the provider's response to this notification.

-Progress note, dated 01/29/2025, indicated a caregiver observed Resident 1 to get dressed after wearing the same clothes for 3 days. Note stated, " Resident is not getting changed in pajamas like s/he is supposed to be getting changed into. Or being taken properly care of."

-Progress note, dated 01/31/2025, indicated Resident 1 was discovered on the floor by his/her door. There were no injuries noted. Resident 1 was encouraged to remain in the common area for frequent and extended supervision.

-Progress note, dated 01/31/2025, indicated Resident 1 was discovered once more by a team member on the floor "in the open seating area outside of the home area." No injuries noted. Vitals were taken and Resident 1's blood pressure was noted to be "lower than desired." Notes did not indicate what Resident 1's blood pressure was. Notes stated, "Have received

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orders for a STAT chest xray [sic] to be performed this evening. Team aware to monitor resident closely."

-Resident 1's record did not indicate when Resident 1 received the STAT chest x-ray or results.

-Resident 1's record did not indicate when Resident 1 was tested for Influenza A or the results of the test.

Surveyor observed an e-mail communication, dated 01/31/2025, with a timestamp of 2:01 PM, provided by Registered Nurse A (RN A). The e-mail reported RN A contacted POA B and notified POA B of Resident 1's condition. RN A communicated Resident 1 to have a persistent weakness with an unsteady gait and a thick/clear mucus secretion coming from his/her mouth. RN A listened to Resident 1's lungs and stated, "it sounds to me as though [his/ her] lungs are inflamed. This is generally indicative of pneumonia or the FLU. We've had verified cases of the Influenza A over the past couple days, so I'd put my money on that being the culprit." RN A then explained a sample was collected from Resident 1 to test for Influenza A and Resident 1 was started on Tylenol for the weekend to help with the inflammation of Resident 1's lungs. Surveyor observed an e-mail communication, dated 02/02/2025, with a timestamp of 5:21 PM. The e-mail communication stated POA B responded to RN A with, "Last Sunday (01/26/2025) I asked them to check if [s/he] had pneumonia because that's what it sounded like."

Surveyor observed an e-mail communication, dated 02/02/2025, with a timestamp of 10:30 PM from POA B to RN A. POA B stated, "I went and

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visited [him/her] today and it looks like [s/he] is in a malnutrition coma. Can somebody put [him/her] on IV (intravenous fluid) or send [him/her] to the hospital?...Are you just going to let [him/her] not eat until [s/he] dies or what?"

On 02/11/2025, at approximately 10:30 AM, Surveyor interviewed RN A. RN A reported POA B was notified of Resident 1's change in condition. RN A reported obtaining a STAT chest x-ray and influenza sample from Resident 1 on 01/31/2025. RN A reported the chest x-ray was to take place within 24 hours and the chest x-ray took place on 02/02/2025, with results provided on 02/03/2025, more than 24 hours after the order. RN A reported staff should have notified an on-call nurse when POA B requested to have Resident 1 sent to the hospital. RN A reported s/he was not aware of the request to send Resident 1 to the hospital until 02/02/2025 due to not being on the schedule. RN A reported s/he responded to the email from POA B on 02/02/2025. RN A was unaware of who POA B spoke with regarding sending Resident 1 to the hospital on 02/02/2025. RN A reported all caregivers were aware of the change in condition protocol and believed Resident 1 should have been sent to the hospital upon the request made by POA B. RN A reported no one followed up to inquire on why the chest x-ray was not completed within 24 hours.

On 02/11/2025, at approximately 10:45 AM, Surveyor interviewed Caregiver C. Caregiver C reported Resident 1 was self sufficient and s/he noticed a "drastic" change in Resident 1's health approximately 3 days before Resident 1 passed away. Resident 1 was described to use a wheelchair a day before s/he passed away due to being very weak. Caregiver C reported staff were feeding Resident 1 and Resident 1 required

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verbal encouragement to eat. Caregiver C denied being asked by POA B to send Resident 1 to the hospital.

On 02/11/2025, at approximately 11:03 AM, Surveyor interviewed Caregiver D. Caregiver D reported Resident 1 was very private and very quiet. Caregiver D reported Resident 1 began to decline approximately 3 days before his/her passing. Caregiver D reported Resident 1 had a cough along with a lot of other residents. Caregiver D reported Resident 1 was always offered fluids and needed encouragement to eat and drink. Caregiver D reported Resident 1's family never asked him/her to send Resident 1 to the hospital. Caregiver D reported Resident 1 was not lethargic and was still eating with assistance prior to his/her passing.

On 02/11/2025, at approximately 11:45 AM Surveyor interviewed Executive Director E (ED E), President F, and RN A. Surveyor asked if the staff were aware of the procedure regarding change in condition. ED E reported that all staff were trained and aware of the change in condition process. ED E reported staff were trained to call the on-call nurse and were aware to call 911 during drastic changes in condition. Surveyor asked if the staff believed more intervention was needed for Resident 1 and should Resident 1 have been sent to the hospital prior to 02/02/2025. RN A, ED E, and President F did not provide an answer. ED E sent Surveyor an email on 02/12/2025, timestamped 4:31 PM, indicating the facility staff believed Resident 1 received prompt and adequate treatment by recognizing Resident 1's change in condition on 01/31/2025 and by notifying Resident 1's medical provider and following all orders in addition to following up with POA B. ED E, RN A and President F could

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not provide information as to why no one from the facility followed up on the STAT chest x-ray or why POA B's request to have Resident 1 seen by a medical provider prior to 01/31/2025 was not completed. ED E, RN A, and President F could not provide information about why POA B's request to send Resident 1 to hospital was not documented.

On 02/14/2025, at approximately 9:00 AM, Surveyor interviewed POA B. POA B reported s/he visited with Resident 1 once a week, normally on Sundays. POA B reported Resident 1 had a cough for 1 month and reported s/he requested for Resident 1 to be seen by a medical provider on or around 01/26/2025. POA B could not recall who s/he spoke with about having Resident 1 be seen by a medical provider. POA B reported s/he also requested for Resident 1 to be given additional fluids and could not recall who s/he spoke with, however, indicated it was someone in the dining area assisting with feeding residents. POA B reported s/he visited the facility on Sunday, 02/02/2025 and noticed Resident 1 did not look good. POA B reported s/he brought in applesauce to give to Resident 1 and a staff member assisted with feeding the applesauce to Resident 1. POA B reported s/he requested to have Resident 1 sent to the hospital and the request was made to the individual assisting with the applesauce. POA B reported s/he was told no one could assist with the request and s/he must wait until 02/03/2025 to have Resident 1 sent to the hospital. POA B did not know the name of the person who assisted Resident 1 with the applesauce on 02/02/2025. POA B reported s/he emailed RN A on 02/02/2025 and requested to have Resident 1 sent to the hospital. POA B reported Resident 1's change in condition impacted his/her ability to ambulate, eat, and

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Y3244	Continued From page 7 breathe freely. POA B reported his/her request to obtain additional medical care for Resident 1 was ignored and not documented. POA B reported Resident 1's chest-x-ray results were provided on 02/03/2025 and indicated Resident 1 had pneumonia. Summary: Resident 1 had a cough for approximately 1 month. Resident 1 had a change in condition on 01/27/2025, where Resident 1 exhibited a left puffy eye with a red streak going down the side of his/her face in addition to the left side of his/her mouth drooping. Resident 1 became lethargic and reportedly wore the same clothing for several days, began to have falls due to weakness, began using a wheelchair for ambulation, and required staff to feed him/her. On 01/31/2025, RN A communicated Resident 1 had a persistent weakness with an unsteady gait and a thick/clear mucus secretion coming from his/her mouth. RN A listened to Resident 1's lungs and identified Resident 1 likely had pneumonia or flu. On 01/31/2025, Resident 1's physician was notified of his/her cough and lung sounds and ordered a STAT x-ray. The STAT x-ray was not conducted until 02/02/2025, more than 24 hours after it was ordered. Resident 1 expired on 02/03/2025. The x-ray results did not come in until 02/03/2025, after Resident 1 expired. Facility staff did not follow up on the STAT x-ray order when it was not completed within 24 hours of the order.	Y3244		