

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0013433</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/22/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>AZURA MEMORY CARE SHEBOYGAN 19</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2629 INDIANA AVENUE SHEBOYGAN, WI 53081</b>
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(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	<p>Initial Comments</p> <p>On 08/19/2024, with information gathered through 08/22/2024, Surveyor reviewed 3 complaints. Three of 3 complaints were unsubstantiated and no new deficiencies were identified.</p> <p>Census 17</p>	N 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE