

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0020808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/30/2026
NAME OF PROVIDER OR SUPPLIER BLUE JAY SPRINGS ASSISTED LIVING AND MEMORY		STREET ADDRESS, CITY, STATE, ZIP CODE 1006 N MILITARY AVE GREEN BAY, WI 54303		
(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 An investigation into 3 complaints was conducted at Blue Jay Springs Assisted Living and Memory Care on 06/30/2026. As a result of this survey 3 of 3 complaints were unsubstantiated. No deficiencies were identified. Census: 38	N 000		

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

TITLE

(X6) DATE