

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018262	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 02/05/2026
NAME OF PROVIDER OR SUPPLIER AZURA MEMORY CARE OF FOX POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 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 02/05/2026, Surveyor completed a verification visit, and 2 complaint investigation at Azura Memory Care of Fox Point. As a result, 1 deficiency was corrected, no deficiencies were identified, and 2 complaints were unsubstantiated. Census: 71	{N 000}		

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

TITLE

(X6) DATE