

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017799	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/04/2024
NAME OF PROVIDER OR SUPPLIER AUBERGE AT BROOKFIELD A MEMORY CARE COMM		STREET ADDRESS, CITY, STATE, ZIP CODE 1105 DAVIDSON RD BROOKFIELD, WI 53045		
(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 06/04/2024, the Bureau of Assisted Living, Southern Regional Office conducted a complaint investigation and verification visit of statement of deficiency (SOD) Y77R15 at Auberge At Brookfield Memory Care Community, located at 1105 Davidson Rd in Brookfield, WI. No citations of noncompliance were issued. The complaint was unsubstantiated. Census: 47 Under statutory provisions of Wis. Stat. Ch. 50, a \$200.00 revisit fee is being assessed.	{N 000}		

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

TITLE

(X6) DATE