

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016852	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 03/20/2025
NAME OF PROVIDER OR SUPPLIER ST CAMILLUS MEMORY CARE NORTH RESIDE			STREET ADDRESS, CITY, STATE, ZIP CODE 10201 W WISCONSIN AVE WAUWATOSA, WI 53226		
(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
Z 001	Initial Comments On 03/20/2025, Surveyor conducted 2 complaint investigations at St Camillus Memory Care North Residence. Two complaints were unsubstantiated. No deficiencies were identified. Census: 52	Z 001			

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

TITLE

(X6) DATE