

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0010354</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/08/2021</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PRO HEALTH CARE REGENCY SENIOR COM NEW BE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>13750 WEST NATIONAL AVENUE NEW BERLIN, WI 53151</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
U 000	<p><b>INITIAL COMMENTS</b></p> <p>On 11/08/2021, Surveyor conducted a complaint investigation at Pro Health Care Regency Senior Community New Berlin.</p> <p>No deficiencies were identified.</p> <p>The complaint was not substantiated.</p> <p>Census: 37</p>	U 000		

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

TITLE

(X6) DATE