

Wisconsin Department of Health Services

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0010349 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 11/21/2023 |
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| NAME OF PROVIDER OR SUPPLIER PRO HEALTH CARE REGENCY SENIOR COMM MUSK | STREET ADDRESS, CITY, STATE, ZIP CODE W181 S8540 LODGE BLVD MUSKEGO, WI 53150 |
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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>INITIAL COMMENTS</p> <p>On 11/21/2023, Surveyor conducted a complaint investigation at Pro Health Care Regency Senior Community Muskego.</p> <p>The complaint was not substantiated.</p> <p>Census: 70 Tenants</p> | U 000 | | |

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

TITLE

(X6) DATE