

Wisconsin Department of Health Services

|  |  |   |   |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>0018348</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>06/27/2023</b> |
|--|--|---|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BELLEVUE RETIREMENT COMMUNITY</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1660 HOFFMAN ROAD<br/>GREEN BAY, WI 54311</b> |
|--|---|

| (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 06/26/2023 with additional information gathered through 06/27/2023, Surveyors conducted a standard survey and investigated 3 complaints. As a result, 3 of 3 complaints were unsubstantiated and no deficiencies were identified.</p> <p>Census: 75</p> | U 000         |   |                    |

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

TITLE

(X6) DATE