

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018219	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 04/14/2025
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE WAUKESHA		STREET ADDRESS, CITY, STATE, ZIP CODE 1701 EAST BROADWAY WAUKESHA, WI 53186		
(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}	INITIAL COMMENTS On 04/14/2025, the Bureau of Assisted Living, Southern Regional Office conducted a verification visit of statement of deficiency (SOD) 90DR12 and a complaint investigation at New Perspective Waukesha, 1701 East Broadway in Waukesha, WI. No citations of noncompliance were issued. The complaint was unsubstantiated. Census: 41 Under statutory provisions of Wis. Stat. Ch. 50, a \$200.00 revisit fee is being assessed.	{U 000}		

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

TITLE

(X6) DATE