

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0013625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 03/27/2025
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE-WEST BEND			STREET ADDRESS, CITY, STATE, ZIP CODE 2130 CONTINENTAL DR WEST BEND, WI 53095		
(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	
{N 000}	Initial Comments A verification visit was conducted on 03/27/2025 for SOD (Statement of Deficiency) - IC9Q11 from 05/09/2024. At this time, on 03/27/2025, a verification visit was also conducted for SOD 2FY311. As a result of this survey all previous deficiencies have been corrected. Per state statutes a \$200 revisit fee was assessed. Census: 34	{N 000}			

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

TITLE

(X6) DATE