

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0013063	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 09/27/2024
NAME OF PROVIDER OR SUPPLIER BETHSAIDA FAMILY HOME 3		STREET ADDRESS, CITY, STATE, ZIP CODE 110 N HIGH POINT RD MADISON, WI 53717			
(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
{M 000}	INITIAL COMMENTS On 09/27/2024, Surveyor conducted a verification visit at Bethsaida Family Home 3, an AFH in Madison. No deficiencies were identified. Statement of Deficiency (SOD) 1J4N11, dated 07/09/2024, was corrected. Census: 4	{M 000}			

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

TITLE

(X6) DATE