Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020726	A. BUILDING: _____ B. WING _____	R 07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL ASSISTED LIVING KAUKAUNA SOUTH	548 FRANCES ST KAUKAUNA, WI 54130

(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 On 06/29/2026, with information gathered through 07/01/2026, Surveyors conducted a verification visit at Bethel Assisted Living Kaukauna South. All previous deficiencies were corrected. As a result of the survey, no new deficiencies will be issued. The facility will be granted a standard license effective 07/01/2026. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 3	{N 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE