Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	0009330		R **05/04/2026**

NAME OF PROVIDER OR SUPPLIER

ELIZABETH RESIDENCE NORTH

STREET ADDRESS, CITY, STATE, ZIP CODE

9329 S 48TH ST
FRANKLIN, WI 53132

(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 05/04/2026, Surveyor completed a verification visit at Elizabeth Residence North. Statement of Deficiency 3KKR11 was corrected and no new deficiencies were identified. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 33	{N 000}		

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