

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0020293	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/09/2025
NAME OF PROVIDER OR SUPPLIER BETHSAIDA AUGUSTA		STREET ADDRESS, CITY, STATE, ZIP CODE 410 AUGUSTA DRIVE 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 05/09/2025, Surveyor conducted a monitoring visit at Bethsaida Augusta, an AFH located in Madison, WI. The facility will be considered a Non-Ambulatory facility. The facility has demonstrated compliance for all required criteria to meet non-ambulatory resident needs. The non-ambulatory status will be effective 05/09/2025.	M 000		

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

TITLE

(X6) DATE