

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017977	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 09/11/2025
NAME OF PROVIDER OR SUPPLIER BETHEL RIPON NORTH		STREET ADDRESS, CITY, STATE, ZIP CODE 530 NORTH UNION STREET RIPON, WI 54971		
(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 at Bethel Ripon North on 09/10/2025 with additional information gathered through 09/11/2025. As a result of this visit the previous deficiencies were corrected and no new deficiencies were identified during the visit. Per state statutes a \$200.00 revisit fee was assessed. Census: 7	{N 000}		

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

TITLE

(X6) DATE