

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0019949	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/14/2025
NAME OF PROVIDER OR SUPPLIER LARSON HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 550 RIVER ROAD COLUMBUS, WI 53925		
(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 01/14/2025, the Bureau of Assisted Living, Southern Regional Office, conducted a verification visit at Larson House, a community-based residential facility (CBRF) located in Columbus, WI. As a result of the survey, 0 deficiencies were identified. All previous deficiencies from Statement of Deficiency (SOD) Y0FJ11, dated 10/02/2024, were corrected. Under statutory provisions of Wis. Stat. Chapter 50, a \$200 revisit fee is being assessed. Census: 36	N 000		

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

TITLE

(X6) DATE