

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0019358	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/25/2025
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NAME OF PROVIDER OR SUPPLIER EMERSON SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 402 RUSTIC DR MADISON, WI 53718
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(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	<p>INITIAL COMMENTS</p> <p>From 02/20/2025 to 02/25/2025, Surveyor conducted a complaint investigation and standard survey at Emerson Senior Living, an AFH in Madison.</p> <p>No deficiencies were identified.</p> <p>The complaint was unsubstantiated.</p> <p>Census: 0</p>	M 000		

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

TITLE

(X6) DATE