STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013427	A. BUILDING: _____ B. WING _____	C 08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE NEW RICHMOND MEMORY CARE	1310 CIRCLE PINE DR NEW RICHMOND, WI 54017

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N 000	Initial Comments On 08/14/2025, with information gathered through 08/19/2025, Surveyor conducted 2 complaint investigations, a self-report review, and a standard licensure survey, at Our House New Richmond Memory Care. Two deficiencies were identified. One of 2 complaints was substantiated. Census: 14	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report an allegation of neglect to	N 158		

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

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N 158	Continued From page 1 the department within 7 days. Resident 6, who is a stand-by assist with showering, was left unattended when Med Technician (MT) U left him/her to inform MT R, who was assisting Resident 1 on the first floor with toileting, that s/he was leaving because s/he did not want to work on floor 2. Findings include: Neglect, as defined in Wisconsin Statue 46.90(1)(f), is the failure of a Resident Care Aide to try to secure or maintain adequate care, services or supervision for an individual, including food, clothing, shelter, or physical or mental health care. Neglect can be an act, omission, or course of conduct and creates significant risk or danger to the individual's physical or mental health. On 03/19/2025, the Department received a concern that residents were neglected, and the provider did not report it to the department. On 08/14/2025, at approximately 1:00 PM, Surveyor interviewed Executive Director (ED) B. Surveyor discussed the concern that had been reported to the department and ED B stated that s/he had investigated a neglect concern involving Resident Care Assistant (RCA) C and RCA D. ED B stated that after the investigation, RCA C and RCA D were terminated. Executive Director B stated s/he filed a report with the Office of Caregiver Quality (OCQ). Surveyor asked for a copy of the report and ED B stated s/he was not able to retrieve it. Surveyor asked to review the internal investigation. On 08/15/2025 at 6:18 AM, Surveyor reached out to OCQ and requested a copy of the provider's	N 158		

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N 158	Continued From page 2	N 158		

report regarding an allegation of neglect on 03/2025.

On 08/15/2025 at 7:51 AM, Surveyor was informed by OCQ that a report had not been filed.

On 08/15/2025 at 10:33 AM, Surveyor emailed Regional Director A and ED B and stated that a report had not been filed with OCQ and requested a copy of the provider's internal investigation into the alleged neglect.

On 08/18/2025 at 10:14 AM, Executive Director B emailed Surveyor the provider's internal investigation. ED B did not comment about the report not being filed with OCQ. Surveyor reviewed the provider's submitted internal investigation which documented:
"03/06/2025 3 pm: [RCA E] reported to [ED B] that on 03/04/2025 [RCA E] arrived early for [his/her] shift around 7-7:30 pm due to the snowstorm and was planning to hang out until [his/her] shift started. [RCA E] stated that [s/he] called on call Lead [sic] mad because [RCA C] and [RCA D] left at 9 pm and they just watched [RCA E] and [RCA F] running around giving [Resident 1] a shower because [s/he] had dry BM (bowel movement) all over [him/her], [his/her] bathroom, and bedroom. [RCA E] stated that [RCA D] stated resident had refused [his/her] blood pressure check for [his/her] vital log after a fall.

3/10/2025 10:24 am: Interviewed [RCA E] who stated on March 4, 2025, [s/he] came into work around 7:15-7:30 PM due to bad weather conditions. When coming into work [RCA D] and [RCA C] were sitting on the couch in the TV room. [RCA E] stated that staff were watching tv [sic]. [RCA E] let [RCA D] and [RCA C] know that [s/he]

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N 158	Continued From page 3	N 158		

contacted [ED B] who approved them to could [sic] come early but not to clock in until 9 pm. While waiting till 9 pm [RCA E] stated [s/he] started getting cleaning supplies together that [s/he] would need for [his/her] shift. When walking down the hallway around 8:15 PM [sic] [RCA E] stated that [s/he] and [RCA F] could smell a bowel movement. [RCA F] and [RCA E] were checking residents' rooms and found [Resident 1] in bed lying in a pink short sleeve shirt with black pants with [his/her] shoes on. [RCA F] and [RCA E] got resident into [his/her] bathroom and when removing resident's pants, resident had dry bowel down [his/her] legs. The resident's bed was soaked, bowel on [his/her] bedroom floor, and all over the resident's bathroom. [RCA F] took the resident to get a shower. While resident went to take a shower [RCA E] stated that [s/he] went to the cleaning room to get the cleaning supplies to clean resident's room. When going to clean the resident's room, [RCA D] and RCA C were standing in the kitchen and then went outside to move their cars to the front to warm up. [RCA E] stated that [s/he] vocalized the [Resident 1] situation and [RCA C] and [RCA D] both went to answer another resident call light. When watching [RCA C] and [RCA D] go to the call light, [RCA E] went back to [room number] to clean while resident was still in the shower with [RCA F]. [RCA E] stated when coming out of resident's room around 8:50 pm and resident was in Pajamas [sic] and in bed after [his/her] shower, it was noted that [RCA C] and [RCA D] left the building without finding [RCA F] or [RCA E]. [RCA E] stated [RCA C] texted [RCA F] saying they yelled that they were leaving and left. [RCA E] called On Call Lead [RCA G] right away stating they were just sitting in the kitchen and on the couch watching tv [sic]. Also, how [RCA C] and [RCA D] left without checking with [RCA F] and

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N 158	Continued From page 4 [RCA E]. [RCA E] stated that after cleaning residents and calling on-call, [s/he] went into the medication room and noticed on resident's vital sheet, a fall, wrote down that resident refused to take vitals when [RCA D] did not step a foot into resident's room as resident was in the shower and room was getting cleaned and [RCA D] left at 9 pm. [RCA E] stated in resident shift notes, [RCA D] wrote about [Resident 1] at 8:20 pm that they asked resident if [s/he] needed help with anything or bathroom and resident refused. [RCA E] stated that resident is hands on and resident needs cueing. When [RCA D] wrote that shift note, resident was in the shower. [RCA E] also explained the shift note and the vital refusal to on-call [Lead RCA G]. Walk throughs were not done due to [RCA F] and [RCA E] cleaning [room number] and resident and [RCA C] and [RCA D] left without communicating in person to [RCA E] and [RCA F]. Narcotic was not completed correctly as evening shift left before doing the Narcotic count. 03/10/2025 11:28 am: [Executive Director B] interviewed [Lead RCA G]. [Lead RCA G] stated that on March 4, 2025 [s/he] got a phone call from [RCA D] @ 8:40 pm asking if [RCA D] and [RCA C] could go home due the extreme weather as [RCA E] and [RCA F] came early due to the weather. [Lead RCA G] was not aware that they had come in early until [RCA D] had told [him/her]. Lead RCA G] stated they could leave at 9 pm if everything was done and [RCA E] and [RCA F] were okay with it. [RCA D] stated that everything was good. On March 4th, 2025, [Lead RCA G] got a phone call from [RCA E] asking why [Lead RCA G] let	N 158		

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N 158	Continued From page 5	N 158		

them go home. [Lead RCA G] stated [s/he] confirmed it with them. [RCA E] stated that [Resident 1] in [room number] was left in dried BM everywhere, resulting in [his/her] needing a shower. BM was all over [his/her] bedroom, [him/herself], and [his/her] bed. [Lead RCA G] apologized to [RCA E] for allowing them to go home early and [Lead RCA G] stated [s/he] would address this situation with [ED B] and [RCA C] left before walk throughs were able to be done.

03/10/2025 11:42 am: [Executive Director B] interviewed [RCA F]. [RCA F] stated that on March 4, 2025 [s/he] came into work around 7:15-7:30 PM due to bad weather conditions. When coming into work [RCA D] and [RCA C] were sitting on the couch in the TV room watching tv. [RCA E] let [RCA D] and [RCA C] know that [s/he] contacted [Executive Director B] who approved them to come early but not to clock in until 9 pm. [RCA F] could smell a bowel movement around 8:15 pm. [RCA F] and [RCA E] were checking residents' rooms and found [Resident 1] in bed laying [sic] in a pink short sleeve shirt with black pants with [his/her] shoes on. [RCA F] and [RCA E] got resident into [his/her] bathroom and when removing resident's pants resident had dry bowel down [his/her] legs. The resident's bed was soaked, bowel on [his/her] bedroom floor, and all over the resident's bathroom. [RCA F] took resident to get a shower. After getting resident out of the shower and nighttime clothes on [sic] [RCA F] stated [s/he] was helping [RCA E] in resident's room when [s/he] got a text message from [RCA C] that they had left. [RCA C] and [RCA D] did not do end of shift walk throughs with on coming staff [RCA E] and [RCA F]. [RCA F] stated they did not complete narcotic count with the oncoming staff and left before completing the task. ...

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N 158	Continued From page 6 Actions Steps Taken Upon Completion of Investigation: Termination of [RCA D] for repeated incidents of failure to do narcotic count appropriately and failure to provide care to a resident. Termination of [RCA C] for falsifying documentation and failure to provide care to a resident. Report [RCA C] and [RCA D] for caregiver misconduct."	N 158		
N 489	83.44(2)(a) Rooms clean and free from odors. The CBRF shall keep all rooms clean and shall make reasonable attempts to keep all rooms free from odors. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that all rooms were clean and free from odor. Resident 1's, Resident 2's and Resident 3's room smelled like urine. Findings include: On 08/14/2025, at approximately 1:30 PM, Surveyor observed Med Passer H administer medications to Resident 2 and Resident 3 in their bedrooms. Surveyor noted a urine-like scent emanating from their bedroom. When Surveyor and Med Passer H exited their rooms, Surveyor asked if Med Passer H detected the urine-like scent. Med Passer H stated, "Yes, the rooms do have that scent. We steam clean the rugs but the scent returns. The residents do not deal with incontinence, so I am thinking it is in the carpet."	N 489		

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N 489	Continued From page 7 On 08/14/2025 at approximately 2:00 PM, Surveyor also detected the scent emanating from Resident 1's room. On 08/14/2025, at approximately 2:30 PM, Surveyor interviewed Regional Director (RD) A and Executive Director (ED) B. RD A explained that as residents moved out, flooring was being replaced with a laminate floor. RD A stated s/he would discuss the concern with corporate and see if residents could be moved to a vacant room while their flooring was replaced.	N 489		