| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0013379 | A. BUILDING: _____ B. WING _____ | R-C 05/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| OUR HOUSE RICHLAND CENTER MEMORY CARE | 240 N ORANGE STREET RICHLAND CENTER, WI 53581 |

| (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<br><br>On 05/19/2025, the Bureau of Assisted Living, Southern Regional Office conducted a standard licensing survey, a verification visit of statement of deficience (SOD) 3JJ211, and a complaint investigation at Our House Richland Center Memory Care located at 240 N Orange Street in Richland Center, Wi.<br><br>One citation of noncompliance was issued. The complaint was unsubstantiated.<br><br>Census: 17<br><br>Under statutory provisions of Wis. Stat. Ch. 50, a $200.00 revisit fee is being assessed. | {N 000} | | |
| N 220 | 83.17(2)(a) Employees screened for communicable disease.<br><br>The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes.<br><br>This Rule is not met as evidenced by:<br>Based on observation, interview, and record review, the provider did not ensure 2 caregivers were screened for clinically apparent | N 220 | | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0013379 | A. BUILDING: _____ B. WING _____ | R-C 05/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| OUR HOUSE RICHLAND CENTER MEMORY CARE | 240 N ORANGE STREET RICHLAND CENTER, WI 53581 |

| (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 220 | Continued From page 1 | N 220 | | |

communicable disease, including tuberculosis, as required.

Caregiver A was not screened for clinically apparent communicable disease, including tuberculosis, as required.
Caregiver B was tested for tuberculosis but not screened for clinically apparent communicable disease, as required.

The findings are:

On 05/19/2025 at approximately 8:30 A.M., Administrator A told Surveyor Caregiver B was one of four caregivers on duty on this day. Administrator A provided Surveyor a list of current caregivers and their dates of hire. Surveyor introduced self to Caregiver B and observed Caregiver B assisting resident's with breakfast in the dining room.

On 05/19/2025 between 11:23 A.M. and 11:45 A.M., Administrator A provided Surveyor with Caregiver A and Caregiver B's employee records for review.
Caregiver A's date of hire was 03/31/2025. Caregiver A's employee record did not include documentation Caregiver A was screened for clinically apparent communicable disease, including tuberculosis, as required. Administrator A told Surveyor Caregiver A's communicable disease screen, including tuberculosis, had not been completed before nor after Caregiver A was hired and began working with residents at the facility. Administrator A said Caregiver A's screening was "just missed."

Caregiver B's date of hire was 09/10/2024. Caregiver B's employee record included documentation Caregiver B's completed step-one

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0013379 | A. BUILDING: _____ B. WING _____ | R-C 05/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| OUR HOUSE RICHLAND CENTER MEMORY CARE | 240 N ORANGE STREET RICHLAND CENTER, WI 53581 |

| (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 220 | Continued From page 2<br><br>tuberculin screening was read on 10/17/2024. Caregiver B's "Risk-based Tuberculosis Screening Questionnaire" including questions related to "communicable disease screen" was signed by Caregiver B on 12/24/2024. The statement regarding a communicable disease screen was not documented and/or signed by a physician, physician assistant, clinical nurse practitioner, or licensed registered nurse [RN]. Administrator A told Surveyor s/he missed forwarding Caregiver B's communicable disease screen questionnaire to be completed by one of the provider's RNs.<br><br>Administrator A told Surveyor s/he would be reviewing all caregiver files to ensure their communicable disease screen, including tuberculosis, were completed to correct this noncompliance. | N 220 | | |