

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0013383	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 02/28/2024
NAME OF PROVIDER OR SUPPLIER OUR HOUSE WISCONSIN DELLS MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1950 STATE HWY 23 WISCONSIN DELLS, WI 53965		
(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 02/28/2024, the Bureau of Assisted Living, Southern Regional Office conducted a verification visit of statement of deficiency (SOD) 6BGX11 at Our House Wisconsin Dells Memory Care, located at 1950 State Road in Wisconsin Dells, WI. No citations of noncompliance were issued. Census: 15 Under statutory provisions of Wis. Stat. Ch. 50, a \$200.00 revisit fee is being assessed.	{N 000}		

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

TITLE

(X6) DATE