STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013424	A. BUILDING: _____ B. WING _____	R-C 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE WAUSAU ASSISTED CARE	210 W CAMPUS DR WAUSAU, WI 54401

(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 03/12/2026, Surveyor conducted a standard licensure survey and verification visit at Our House Wausau Assisted Care. Two deficiencies were identified. Census: 14 Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed.	{N 000}		
N 396	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure there were sufficient numbers of employees on a 24-hour basis to meet the needs of 2 of 2 residents reviewed. Resident 1 required the assistance of 2 staff members to transfer safely. Resident 2 required assistance from 2 staff members to transfer when s/he was feeling weak. The provider did not schedule 2 staff on a 24-hour basis. Findings include: RESIDENT 1 On 03/12/2026, Surveyor reviewed Resident 1's record. On 02/15/2025, Resident 1 was admitted to the facility. S/he had multiple diagnoses including: Alzheimer's disease, syncope and collapse,	N 396		

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

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N 396	Continued From page 1 muscle weakness, and unspecified falls. On 02/17/2025, Resident 1 was admitted to hospice. Progress notes for Resident 1 included the following: 02/10/2026 - "Mobility Change: staff helped resident out of bed onto toilet, resident cannot hold self up, turn and sit. may [sic] be 2 assist is not safe alone with one staff, will be using commode from now on." 02/13/2026 - "Tiredness/Weakness: This morning, staff noticed resident was very weak; resident kept falling back in [his/her] bed when staff tried to sit [him/her] up. It took two staff members to complete [his/her] ADL's (activities of daily living) ..." 02/14/2026 - "Mobility/Change: all throughout day resident will not lift selft [sic] or help relying on team members took two team members to help onto commode in middleof [sic] night, took two staff and resident barely made it onto commode saftley [sic] ..." 02/15/2026 - "Resident has needed two staff members to help with cares ..." 02/16/2026 - " ...Team members continue to utilize 2 team members for transfers when resident is weak ..." On 02/25/2026, hospice orders read, in part: "Assist of 2 & Hoyer lift for all transfers." Resident 1's individual service plan (ISP), with a print date of 03/12/2026, read, in part: "Toileting:	N 396		

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N 396	Continued From page 2 Two Assist-requires two team members to cue to toilet, perform peri-cares, and/or change incontinence products ... Transfers: Two Assist-requires two team members to transfer in/out of chairs, bed, other devises and/or use of Hoyer Lift or Sit-to-Stand. Resident uses a hoyer [sic] lift for transfers. If resident wishes to be up on night shift, team member to get help from sister house to transfer with hoyer [sic]. Resident is a two person for transfers only." RESIDENT 2 On 03/12/2026, Surveyor reviewed Resident 2's record. On 12/19/2024, Resident 2 was admitted to the facility. Resident 2 had multiple diagnoses including: chronic myeloid leukemia, spindle cell sarcoma, weakness, and failure to thrive. On 12/04/2025, Resident 2 was admitted to hospice. Progress notes for Resident 2 included the following: 03/02/2026 - "Communication Change: Resident fell on NOC (overnight) shift, very confused. Very weak, cannot stand [him/herself] up tall or walk/shift to the right or left well [sic] puting [sic] all [his/her] body weight onto both caregivers ..." 03/08/2026 - "Resident seemed very weak today and needed two staff to assist on commode ..." Resident 2's ISP, with a print date of 03/12/2026, read, in part: "Resident requires 2 team members for transfers only when resident is weak."	N 396		

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N 396	Continued From page 3 On 03/12/2026, Surveyor reviewed the employee schedule from 02/01/2026 to 03/12/2026. There was 1 staff member scheduled to work the overnight shift from 10:00 p.m. to 6:00 a.m., except on 02/05/2026 and 03/04/2026 when there were 2 staff working from 10:00 p.m. to 6:00 a.m. On 03/12/2026 at approximately 3:30 p.m., Surveyor interviewed Residence Director (RD) A. RD A told Surveyor they schedule 1 person for the overnight shift. RD A said staff were to call the other community-based resident facility, located next door, if they needed a second person for transfers. The provider did not ensure there were always 2 staff members working on a 24-hour basis to meet the needs of Resident 1 and Resident 2 to transfer safely.	N 396		
N 419	83.37(3)(c) Medication storage: locked cabinet. Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all medication storage areas were locked. Findings include: The provider is licensed to care for up to 20 residents in the client groups of irreversible dementia/Alzheimer's disease and advanced age. On 03/12/2026 at 10:10 a.m., Surveyor observed	N 419		

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N 419	Continued From page 4 the medication cart and medication refrigerator located in the dining area. The medication cart was unlocked. Surveyor was able to open the drawers to the medication cart. The medication refrigerator was unlocked. The padlock was placed on top of the refrigerator. Surveyor opened the refrigerator and observed there was insulin and eye drops stored in there. There were no staff members present within eyesight of the medication cart and medication refrigerator. At 10:43 a.m., Surveyor observed 2 hospice workers and Caregiver B at the table near the medication cart and refrigerator. The medication cart was locked, but the medication refrigerator still did not have the padlock in place. At approximately 11:15 a.m., Surveyor observed the medication cart with Caregiver B. The medication cart contained all medications for the residents including schedule II narcotics that were stored in a locked drawer in the medication cart. Surveyor explained observation of the medication cart and refrigerator being unlocked when Surveyor toured the facility. Caregiver B said, "My bad." Caregiver B told Surveyor s/he had to assist with a resident, but it was policy to keep it locked. The provider did not ensure all medication storage was locked.	N 419		