Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013375	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE REEDSBURG MEMORY CARE	1135 17TH CT REEDSBURG, WI 53959

(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 02/05/2026, Surveyor conducted a complaint investigation and verification visit at Our House Reedsburg Memory Care, a CBRF located in Reedsburg, WI. As a result of the investigation, 1 violation of Chapter DHS 83 was issued. The complaint was substantiated. Two violations from previous Statement of Deficiency (SOD) ADUL11 dated 01/28/2025 were corrected. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed.	{N 000}		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Resident 1 received prescribed medications in the dosage and at intervals prescribed by a practitioner. Resident 1's Losartan was put on hold by Resident 1's Primary Care Physician (PCP) on 10/15/2025, Resident continued to receive Losartan until 10/22/2025 when it was discontinued.	N 352		

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

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N 352	Continued From page 1 Findings include: On 01/12/2026, the Department received a complaint alleging residents were receiving medications that were put on hold or discontinued. On 02/05/2026 at 9:30 AM, Surveyor reviewed Resident 1's medical record. Resident 1 was admitted 07/09/2025 with diagnoses that include but are not limited to: Dementia with progressive decline, depression, history of falls, HTN. There was an order written by Resident 1's PCP directing facility to put Resident 1's Losartan on hold, but not discard due to blood pressure readings. According to Resident 1's Medication Administration Record (MAR) for October 2025. Resident 1 continued to receive Losartan from 10/15/2025 until 10/22/2025 when Losartan was discontinued by Resident 1's PCP. On 02/05/2026 at 11:00 AM, Surveyor interviewed Residence Director A. Residence Director A acknowledged that there was an order from Resident 1's PCP to hold Resident 1's Losartan. Residence Director A acknowledged that Resident 1 continued to receive Losartan from 10/15/2025 until 10/22/2025 when Losartan was discontinued. Residence Director A stated that during that time there was a different Director and s/he is no longer with the company. Residence Director A stated that Resident 1 should not have received Losartan after it was put on hold 10/15/2025 by Resident 1's PCP.	N 352		