STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013376	A. BUILDING: _____ B. WING _____	R 02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE BARABOO ASSISTED CARE	1200 WASHINGTON AVE BARABOO, WI 53913

(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 02/10/2026, Surveyor conducted verification visits and a complaint investigation at Our House Baraboo Assisted Care. One deficiency was identified. One of 1 defiency was a repeat violation (see Statement of Deficiency (SOD) CTOQ11 and SOD D5T111. Complaint was unsubstantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census 13	{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 administer medications in the intervals prescribed by a practitioner for 1 of 1 resident. This is a repeat deficiency. See Statement of Deficiency (SOD) CTOQ11, dated 05/09/2023, and SOD D5T111, dated 08/07/2025. Resident 2's Novolog Flexpen (insulin) was not administered as prescribed.	{N 352}		

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
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{N 352}	Continued From page 1 Findings include: On 02/10/2026, Surveyor reviewed Resident 2's record. Resident 2 moved into the facility, 12/28/2024, with diagnosis including diabetes. Resident 2's December 2025 Medication Administration Record (MAR) documented: "Novolog Flexpen 100 U/ML (Units/Milliliter) - Inject 22 Units with meals plus sliding scale." Sliding Scale: 151 - 200 = 2 U; 201 - 250 = 4 U; 251 - 300 = 6 U; 301 - 350 = 8 U; 351 - 400 = 10 U The MAR documented: 12/03 8:00 AM - 192 BS (blood sugar) - 0 Sliding Units administered - Should have administered 2 Units 12/06 8:00 AM - 186 BS - 0 Sliding Units administered - Should have administered 2 Units 12/08 8:00 AM - 199 BS - 0 Sliding Units administered - Should have administered 2 Units 12/06 8:00 AM - 367 BS - 8 Sliding Units administered - Should have administered 10 Units 12/02 12:00 PM - 191 BS - 0 Sliding Units administered - Should have administered 2 Units 12/06 12:00 PM - 199 BS - 0 Sliding Units administered - Should have administered 2 Units Resident 2's January 2026 MAR documented: "Novolog Flexpen 100 U/ML - Inject 20 Units plus corrections scale at Breakfast and Supper." "Novolog Flexpen 100 U/ML - Inject 14 Units plus corrections scale at Lunch." Correction Scale: 151 - 200 = 2 U; 201 - 250 = 4 U; 251 - 300 = 6 U; 301 - 350 = 8 U; 351 - 400 = 10 U	{N 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{N 352}	Continued From page 2 The MAR documented: 01/17 8:00 AM - 222 BS - 26 Units administered - Should have administered 24 Units 01/21 8:00 AM - 207 BS - 20 Units administered - Should have administered 24 Units 01/17 12:00 PM - 186 BS - 24 Units administered - Should have administered 16 Units On 02/10/2026, at approximately 1:00 PM, Surveyor interviewed Administrator A, Regional Director of Operations F and Registered Nurse G. Surveyor reviewed Resident 2's MARs with them. Registered Nurse G confirmed that staff had documented the wrong sliding scale units when administering Resident 2's insulin. Registered Nurse G commented that Resident 2's insulin dosage changed on a regular basis which was leading to confusion among the med passers.	{N 352}		