STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013428	A. BUILDING: _____ B. WING _____	C 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE MENOMONIE MEMORY CARE	820 17TH AVENUE MENOMONIE, WI 54751

(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 12/02/2025, Surveyor completed a complaint investigation and abbreviated licensure survey at Our House Menomonie Memory Care. Data collected through 12/09/2025. Two of 3 complaints were substantiated. Three deficiencies were identified. Census: 19	N 000		
N 171	83.12(5)(c) Notification: change of services or charges. The CBRF shall give the resident or the resident ' s legal representative a 30-day written notice of any change in services available or in charges for services that will be in effect for more than 30 days. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident (Resident 1) or his/her legal representatives were given a 30-day written notice of a change in charge for services that would be in effect for more than 30 days. Findings include: On 09/29/2025, the Department received a complaint that level of care fees were being increased without notification. On 12/02/2025 at 12:10 PM, Surveyor interviewed Regional Director (RD) A about how the provider determined the monthly rates for residents. RD A explained that each resident pays a monthly base rent and an additional daily care	N 171		

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

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N 171	Continued From page 1	N 171		

fee, which was determined by the resident's care plan. A point system was used to calculate the care fee. The care fee was reviewed every 30 days and updated if needed. If a resident's points decreased, the lower rate took effect immediately. If the points increased and the rate was going to rise, the provider would issue a 30-day notice of the increase. RD A stated that notices were sent whenever a rate was adjusted, and that any rate increase would not take effect for 30 days.

At 12:15 PM, Surveyor reviewed Resident 2's monthly ledger for August, September, and October of 2025.

-The August 2025 bill showed a rent rate of $5,625 and a care fee based on a daily rate of $52.50 for 30.5 days, totaling $1,601.25
-The September 2025 bill showed a rent rate of $5,625 and a care fee based on a daily rate of $52.50 for 30.5 days, totaling $1,601.25
-The October 2025 bill showed a rent rate of $5,625 and a care fee based on a daily rate of $100.50 for 30 days, totaling $3,015

Surveyor requested documentation of the notification sent to Resident 2's legal representative regarding the October rate increase. RD A stated s/he would look for the letter and send it via e-mail.

On 12/04/2025 at 2:20 PM, Surveyor received an e-mail from RD A that stated s/he was unable to locate the letter. RD A stated that the provider would be changing their policy moving forward, and that all notifications will now be sent via e-mail to ensure a record was kept.

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N 387	Continued From page 2	N 387		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident, and their legal representatives were involved in developing their individual service plans (ISP), when their ISPs were not signed by the resident or their legal representative, acknowledging their involvement in, understanding of, and agreement with the plan for 2 of 2 residents reviewed (Resident 1 and Resident 3). Findings include: On 10/20/2025, the Department received a complaint that ISPs were not being provided to or signed by legal representatives.	N 387		

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N 387	Continued From page 3 On 12/02/2025, Surveyor reviewed Resident 1's and Resident 3's records. Resident 1 was admitted to the facility on 04/30/2025. Resident 1 had an activated power of attorney (POA). Resident 1's admission ISP did not contain a signature from his/her POA. Resident 1 also had two additional ISPs in his/her record dated 07/29/2025 and 09/02/2025 that did not contain signatures. At approximately 10:53 AM, Executive Director (ED) B stated that the initial ISP should have been signed with the admission paperwork. ED B stated s/he was not employed at the time Resident 1 was admitted and therefore could not answer what occurred prior to his/her employment. ED B stated that in their computer system, if the user does not select archive when updating a care plan, the system will not save the previous care plan or display the changes made. Resident 3 was admitted to the facility on 08/01/2023. Resident 3 had an activated POA. At 10:56 AM, Surveyor reviewed Resident 3's ISP with ED B. Resident 3's ISP dated 11/20/2025 and 6/12/2025 did not contain evidence of a signature from Resident 3's POA. The last signed ISP in Resident 3's chart was dated 08/23/2024. At 11:45 AM, Surveyor interviewed Regional Director (RD) A. RD A stated that they recently identified a few issues in their ISP process as they navigated a new computer system. At 12:00 PM, RD A stated the computer system	N 387		

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N 387	Continued From page 4 sends electronic documents that request signatures for the ISPs. The system would continue to send updates and reminders if the POA did not sign. RD A stated if the POA refused to sign the care plan, they would ask for the reason and explain that facility policy required care plans to be updated and signed on a regular basis. At 12:20 PM RD stated they should have followed up more effectively with residents' POAs to ensure that the ISPs were signed.	N 387		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 2's individual service plan (ISP) was implemented as written. Findings include: On 10/02/2025, the Department received a complaint indicating that safety interventions were not being followed. On 12/02/2025 at approximately 10 AM, Surveyor reviewed Resident 2's record. Resident 2's Care Plan updated 09/03/2025, read in part: "Wandering: Refuses to be redirected, team unable to redirect. Resident has a history wandering into other resident rooms and attempting to leave the community. Resident is on [sic] line of sight. Resident Care Assistant	N 388		

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N 388	Continued From page 5 (RCA) is [sic] assigned as the line-of-sight person each shift, which is designated by a lanyard. Resident has a door alarm above [his/her] door. When resident is in [his/her] room [s/he] is to be on 15 min (minute) checks but as soon as [s/he] leaves [his/her] room [sic] team member assigned to line-of-sight is to respond immediately to the hallway to ensure line of sight of the resident. RCA is to then keep resident in their visual line of sight at all times to prevent them from enter [sic] other rooms, approaching residents when agitated, ect. [sic] If team member [sic] is wandering in halls, then the team member should be with the resident the entire time. If team member is [sic] assigned to line of sight needs [sic] cannot watch the resident for any reason, then they will need to give another team member the designated item to assign them to line of sight temporarily until they are able to return to the line of sight position." A progress note dated 09/02/2025 at 2:42 PM, indicated Resident 2 was involved in a resident-to-resident altercation on 09/01/2025 at 8:10 PM. A progress note dated 09/02/2025 at 3:51 PM, read: "Resident had behavior where [s/he] entered another resident's room and scratched resident [sic] and had an argument with resident. Resident was redirected to [his/her] room. Resident to be on line-of-sight staff when awake. Resident will have a motion sensor in [his/her] room as well." A progress note dated 09/03/2025 at 11:17 AM, read: "Residents ISP has been updated and put in the ISP binder. Please make sure that you read and sign it by the end of your next shift."	N 388		

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N 388	Continued From page 6 A progress note dated 09/18/2025 at 1:27 PM, indicated Resident 2 was involved in another resident-to-resident altercation on 09/16/2025 at 5:30 PM. A progress note dated 09/18/2025 at 1:34 PM, read: "Please read and sign off on residents updated isp/careplan within 24 hours of your next working shift. New interventions: Medication Evaluation requested from hospice, offer resident to do a puzzle, and re-educate team on line-of-sight at all times, as well as provide an object to the team member who is to be the line of sight person so they understand they are the designated line of sight person." On 12/02/2025 at approximately at 11:40 AM, Surveyor interviewed Regional Director (RD) A. RD A stated that on 09/01/2025 they implemented line-of-sight staffing when Resident 2 was awake. They also implemented a motion sensor. Staff assigned to provide line-of-sight supervision during their shift were required to wear a lanyard for identification. At 11:51 AM, Surveyor interviewed RD A about how the 09/16/2025 incident happened. RD A stated that the incident resulted from an "error on our end". RD A explained that they were initially informed the situation was not related to line-of-sight supervision; however, an additional investigation revealed that the assigned line-of-sight staff had stepped away. RD A stated that both residents' POAs were notified immediately. The facility did not ensure that the new line-of-sight intervention outlined in Resident 2's individual service plan was consistently implemented.	N 388		

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