

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0013377	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/07/2025
NAME OF PROVIDER OR SUPPLIER OUR HOUSE CAMBRIDGE ASSISTED CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 201 W MADISON STREET CAMBRIDGE, WI 53523		
(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 07/07/2025, Surveyor conducted a complaint investigation at Our House Cambridge Assisted Care, a CBRF in Cambridge. No deficiencies were identified. The complaint was unsubstantiated. Census: 13	N 000		

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

TITLE

(X6) DATE