

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0013445	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/02/2025
NAME OF PROVIDER OR SUPPLIER OUR HOUSE WI RAPIDS ASSISTED CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2941 16TH ST SOUTH WISCONSIN RAPIDS, WI 54494		
(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 09/02/2025, Surveyor conducted an abbreviated survey and complaint investigation at Our House WI Rapids Assisted Care. The complaint was unsubstantiated and no deficiencies were identified. Census: 14	N 000		

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

TITLE

(X6) DATE