STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013422	A. BUILDING: _____ B. WING _____	C 12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE WAUSAU MEMORY CARE	220 W CAMPUS DRIVE WAUSAU, WI 54401

(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 conducted 2 complaint investigations and a standard licensure survey at Our House Wausau Memory Care. Two of 2 complaints were unsubstantiated. Two deficiencies were identified. One of 2 deficiencies was a repeat deficiency. See Statement of Deficiency (SOD) WCRF11, dated 01/28/2020. Census: 15	N 000		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not review and revise 1 of 2 resident's individual service plan (ISP) reviewed, when there was a change in Resident 1's ability to ambulate and transfer.	N 389		

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
	0013422	A. BUILDING: _____ B. WING _____	C 12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE WAUSAU MEMORY CARE	220 W CAMPUS DRIVE WAUSAU, WI 54401

(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 389	Continued From page 1 This is a repeat deficiency. See Statement of Deficiency (SOD) WCRF11, dated 01/28/2020. Findings include: On 12/02/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 03/10/2025. S/he had multiple diagnoses including dementia, muscle weakness, and adult failure to thrive. Resident 1's ISP, with a print date of 12/02/2025, read in part: Problems/Needs: "Ambulation: One assist: requires one team member to assist resident/tenant in ambulation with or without use of assistive devices such as walker, cane, walking belt, etc. Resident ambulates with one assist." Problems/Needs: "Transfers: One Assist-requires one team member to transfer in/out of chairs, bed, and other devices. OR use of Sit to Stand Lift. Resident requires assistance in transferring. [S/he] does use 4ww (wheeled walker)." A hospice order, dated 10/27/2025, read: "Hoyer lift w/ (with) 2 assist for all transfers." On 12/02/2025 at approximately 4:15 p.m., Surveyor interviewed Assistant Director (AD) A, Executive Director (ED) B from a different region, and Residence Director (RD) C from the facility located next door. Surveyor asked who was responsible for updating ISPs. ED B told Surveyor the director would be responsible for doing the initial ISP, the 30-day ISP, and quarterly ISPs. S/he said both the director and assistant director	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013422	A. BUILDING: _____ B. WING _____	C 12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE WAUSAU MEMORY CARE	220 W CAMPUS DRIVE WAUSAU, WI 54401

(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 389	Continued From page 2 would be responsible for updating ISPs with changes in condition. Surveyor explained the discrepancy between Resident 1's ISP and his/her hospice orders. Surveyor asked if Resident 1 still ambulated. AD A told Surveyor s/he did not. Surveyor asked how staff transfer Resident 1. AD A said s/he thought Resident 1 was given a Hoyer lift, but Resident 1 was too scared to use it. AD A was not sure how staff were transferring Resident 1. RD C left the room to go ask the staff working how they transferred Resident 1. RD C returned and said staff said they transfer Resident 1 with a sit to stand lift and 2 staff. Surveyor asked if this information was relayed to hospice. AD A said s/he did not know for sure. Surveyor Note: A Hoyer is a mechanical lift that assists in lifting a resident by the use of a hammock type sling that attaches to the lift. The resident does not bear any weight, and the lift is maneuvered by staff to transfer a resident from one surface (such as a bed) to another surface (such as a wheelchair). A Sit to Stand is also a mechanical lift. This type of lift uses a belt around the resident's midsection that attaches to the lift. The resident still bears weight and holds on to the lift with their hands while staff move the resident in the lift from one surface to another. (Information retrieved on 12/03/2025 from: https://www.thresholdot.com/blog-2/what-is-the-difference-between-a-hoyer-lift-and-a-sit-to-stand-lift). The provider did not review and revise Resident 1's ISP when s/he had a change in his/her abilities to ambulate and transfer.	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013422	A. BUILDING: _____ B. WING _____	C 12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE WAUSAU MEMORY CARE	220 W CAMPUS DRIVE WAUSAU, WI 54401

(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 507	Continued From page 3	N 507		
N 507	83.46(1)(f) Combustibles. Combustible materials shall not be placed within 3 feet of any furnace, boiler, water heater, fireplace or other similar equipment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure combustible materials were not placed within 3 feet of the water heater. Findings include: On 12/02/2025 at approximately 4:00 p.m., Surveyor observed the furnace rooms with Caregiver D. The furnace room near the laundry room contained plastic totes stacked on top of each other. The totes were within 3 feet of the hot water heater. Surveyor opened the tote that was on top, and it was full of paper manilla envelopes. On 12/02/2025 at approximately 4:15 p.m., Surveyor interviewed Assistant Director (AD) A, Executive Director (ED) B from a different region, and Residence Director (RD) C from the facility located next door. Surveyor shared observation of the combustible materials located within 3 feet of hot water heater. ED B noted the safety concern and told Surveyor the items would be removed.	N 507		