

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0013383	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 04/13/2026
NAME OF PROVIDER OR SUPPLIER OUR HOUSE WISCONSIN DELLS MEMORY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1950 STATE HWY 23 WISCONSIN DELLS, WI 53965		
(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 04/13/2026, Surveyor conducted a verification visit at Our House Wisconsin Dells Memory Care, located in Wisconsin Dells, WI. No deficiencies were identified. Statement of Deficiency (SOD) L8ER11, dated 11/12/2025, was corrected. Under statutory provisions of Wis. Stat. Ch. 50, a \$200.00 revisit fee is being assessed. Census: 20	{N 000}			

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

TITLE

(X6) DATE