STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013381	A. BUILDING: _____ B. WING _____	C 03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE JANESVILLE MEMORY CARE	4333 PHEASANT RUN RD JANESVILLE, WI 53546

(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 03/31/2026, Surveyor conducted a complaint investigation at Our House Janesville Memory Care, a CBRF in Janesville. Two deficiencies were identified. Complaint was substantiated. Census: 14	N 000		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the legal representative of 2 of 2 residents reviewed was immediately notified when there was an incident affecting the residents. Resident 1's legal guardian was not notified of incidents where s/he was hit by a peer from 01/30/2026 through 03/01/2026. Resident 2's legal representative was not notified of 4 incidents of him/her aggressing against a peer from 01/30/2026 through 03/01/2026.	N 169		

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

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N 169	Continued From page 1 Findings include: On 03/31/2026 at approximately 1:30 p.m., Surveyor reviewed resident records and identified the following concerns: Example 1 - Resident 1: Resident 1 was admitted to the provider's facility on 01/09/2020 with diagnosis of major neurocognitive disorder with behavioral disturbance. Resident 1 had a legal guardian. Resident 1's record, dated 01/01/2026 through 03/31/2026, documented the following concerns with resident-to-resident altercations: -01/30/2026 8:24 p.m. Altercation in common area/hallway, Guardian not notified. -02/12/2026 8:46 p.m. Altercation in common area/hallway, Guardian not notified. -02/20/2026 10:59 p.m. Altercation in common area/kitchen, Guardian not notified. -02/22/2026 1:28 p.m. Altercation in common area/hallway, Guardian not notified. Example 2 - Resident 2: Resident 3 was admitted to the provider's facility on 09/23/2024 with diagnoses including dementia. Resident 2 had an activated power of attorney. Resident 2's record, dated 01/01/2026 through 03/31/2026 documented the following concerns with aggression towards a peer: -01/30/2026 10:00 p.m. Altercation with peer in hallway, POA not notified. -02/12/2026 4:13 p.m. Altercation with peer in common area/hallway, POA not notified.	N 169		

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N 169	Continued From page 2 -02/21/2026 7:00 a.m. Altercation with peer in common area/hallway, POA not notified. -02/22/2026 1:34 p.m. Altercation with peer in common area/hallway, POA not notified. On 03/31/2026 at approximately 3:30 p.m., Surveyor reviewed concern with Executive Director A that Resident 1 and Resident 2 had several altercations and the legal guardian/POA were not notified. Executive Director A acknowledged Surveyor's concern and stated that s/he was unaware that the facility had to notify the legal guardian/POA for these incidents. Executive Director A stated that s/he had since had a meeting in the beginning of March 2026 with the resident guardians/POA's involved and will notify of these incidents going forward.	N 169		
N 433	83.38(1)(i) Behavior management. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Behavior management. The CBRF shall provide services to manage resident ' s behaviors that may be harmful to themselves or others. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide services to manage Resident 2's behaviors while at the facility to keep Resident 1 safe. Findings include:	N 433		

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N 433	Continued From page 3 On 03/31/2026, Surveyor conducted a complaint investigation. The provider is licensed as a class CNA (non-ambulatory) community based residential facility (CBRF) able to serve up to 16 residents within the client group of irreversible dementia/Alzheimer's and advanced aged. On 03/31/2026 at 1:30 p.m., Surveyor requested Resident 1 and Resident 2's records, including the most current Individual Service Plan (ISP) and progress notes. Surveyor reviewed progress notes that documented the following for Resident 1 and Resident 2: Resident 1- -01/30/2026 8:24 p.m. Resident to Resident altercation, "[Resident 1] stated that [man/woman] walked past him/her and hit his/her scalp. Heard [Resident 1] start to get agitated and yell in the hall past the med room. [Staff] went towards resident and seen a figure go into apartment [room number] along with [Resident 1] holding scalp and yelling [s/he] just bit me in the scalp." -02/08/2026 11:34 p.m., "Before dinner [Resident 1] had an altercation with another in [Resident 2] (sic). [Resident 1] was seen in hallway after yelling about [him/her] slapping [him/her]. Writer did not hear the slap but could see [Resident 2] pulling hands away from the other and from a striking position. Writer wheeled [Resident 1] back out after telling both we could it (sic) be hitting, slapping or arguing with each other ..." -02/12/2026 8:46 p.m. Resident to Resident Altercation, "[s/he] tryed (sic) to kill my head. [Staff] heard [Resident 2] yell and [Resident 2] scream. -02/20/2026 10:59 p.m., Resident to Resident	N 433		

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N 433	Continued From page 4 Altercation, [Resident 2] went back into room and [Resident 1] yelled [s/he] just hit me, im (sic) tired of this. [S/he] needs to get [his/her] [body part] beat and to stop this. After staff heard [Resident 1] yelling, all went toward [room number]. [Resident 2] was standing in doorway and [Resident 1] was in [his/her] wheelchair near door in hallway. Writer did not see intail (sic) hit but could see [Resident 2] putting hand down from the striking position.." -02/22/2026 1:28 p.m. Resident to Resident Altercation, "[Resident 1] was smacked in the head by [Resident 2]. When staff went to the situation [Resident 2] was already back in [his/her] room with the door locked. Staff heard [Resident 1] say [s/he] hit me and saw [Resident 2] retreating back to [his/her] room. a visitor also stated that [s/he] just hit [him/her]. -03/18/2026 9:47 p.m. Resident to Resident Altercation, "[s/he] just slapped me in the face! Writer quickly came out of med room after hearing [Resident 1] yell. [Resident 2] was quickly walking awayfrom (sic) near [Resident 1] to opposite side of facility. [Resident 1] kept stating, telling staff, and other residents about situation and that [s/he] keeps beating my [body part]. [s/he] just slapped me across the face! [Resident 1] pointed near left temple, had a bit of redness at the time of situation is gone as of 9:40pm." Resident 2- -01/31/2026 2:10 a.m. Late Entry for 01/30/2026 " ...Around 8pm another resident [Resident1] was in their wheelchair sitting in the hallway as [Resident 2] was walking past. While staff wer in dining room we heard [Resident 1] yelling at someone to stop that and when approaching staff seen a figure walk away towards [room #], then [s/he] stated a [man/woman] bit me on the head	N 433		

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N 433	Continued From page 5 ...when staff was telling [3rd shift staff] the update, other [staff] chimed in and stated that [s/he] had seen [Resident 2] (not just a figure and they were the only other person outside of staff that were in the halls at that time) walking back once we reached other [Resident 1] to access the problem." -02/08/2026 11: 14 p.m., Resident to Resident Altercation, "Resident in [room #] stated to [Resident 1] "don't do that. Stop it" due to [Resident 1] opening [his/her] door. [s/he] went back into room after writer said we can touch or hit others no matter what. [Resident 1] involved stated "[s/he] just hit me, im tired of this. [S/he] needs to get [his/her] [body part] beat and stop this." "Writer walked out of med room and could hear both residents started to yell. Writer quickly went to turn corner to see [room #]. [Resident 2] was standing outside of door while [Resident 1] was in wheelchair also near door. Writer did not see initial argument start of the hit to [Resident 1] but seen [Resident 2] moving [his/her] hand back from striking position once getting over there and right after [Resident 1] started to yell ..." -02/12/2026 4:13 p.m., Resident to Resident Altercation, "[s/he] opened my door. [Staff] heard [him/her] yell and [him/her] scream out." -02/21/2026 7:00 a.m. Resident to Resident Altercation, "[Resident 2] did not do or say anything after altercation just went back into room before staff got there. [Resident 1] involved stated '[s/he] bit me on the head!" "Staff heard [Resident 1] yelling about getting bit on the head. When staff went back we could see a figure walk back into [Resident 2's room #] while [Resident 1] was outside the doorway." -02/22/2026 1:34 p.m. Resident to Resident Altercation, "[Resident 1] was smacked in the head by [Resident 2]. When staff went to the situation [Resident 2] was already back in	N 433		

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[his/her] room with the door locked. Staff heard [Resident 1] say "[s/he] hit me." "and saw [Resident 2] retreating back to [his/her] room." -03/18/2026 10:00 p.m. Resident to Resident Altercation, "stayed silent. [Resident 1] stated outloud (sic) [Resident 2] walked past and slapped them in the face. When writer seen [Resident 2] quickly walking past writer tried to ask why [s/he] did that and want (sic) happened (hit unprovoked writer did not see but could hear it). [Resident 2] stayed silent, walked past to other side of building then back to room a couple minutes later. Writer did not see [Resident 2] make contact with [Resident 1] but heard the smack right before [Resident 1] yelled ..."

On 03/31/2026 at approximately 2:30 p.m., Surveyor reviewed Resident 1 and Resident 2's ISP's. The ISP's documented the following:

Resident 1 -

Resident 1's ISP, dated 12/19/2025, stated that Resident 1 "Requires team member to reorient resident/tenant due to moderate confusion exhibited." There was nothing documented regarding the supervision required to keep Resident 1 safe from Resident 2.

Resident 2 -

Resident 2's ISP, dated 12/16/2025, said that Resident 2's physical/verbal abuse section stated "Team member is to monitor resident for any signs of physical/verbal abuse. If team member sees signs of physical/ verbal abuse team member should document in a note and also include what interventions were used and if the interventions were effective. Resident/tenant exhibits physical and/or verbal abuse towards

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themselves or others. Requires team member to provide interventions to address behavior." The facility did not have any documented interventions in the ISP from 01/30/2026 through 03/18/2026.

On 03/31/2026 at 2:30 p.m., Surveyor interviewed Caregiver B. Caregiver B stated that Resident 1 had been wheeling down by Resident 2's doorway because s/he gets confused. Caregiver B stated that Resident 2 had just been put on a 15-minute check program within the last week and that was helping with the hitting situation. Caregiver B stated that the staff are trying to keep Resident 1 and Resident 2 away from each other. Caregiver B mentioned that Resident 2 was given a notice of discharge.

On 03/31/2026 at 3:30 p.m., Surveyor interviewed Executive Director A and asked about Resident 1 and Resident 2's progress notes and the documented incidents between the residents. Executive Director A stated that Resident 2 is a very quiet [guy/girl] but gets upset when [Resident 1] messes with [his/her] door. Executive Director A stated that staff were documenting the incidents and trying to keep Resident 1 away from Resident 2.

On 03/31/2026 at 4:00 p.m., Surveyor reviewed the concern of lack of interventions and behavior management with Resident 2 with Executive Director A. Executive Director A acknowledged that Resident 2 had several documented incidents of unsupervised time with Resident 1. Executive Director A stated that the facility was working with the team on coming up with interventions. Executive Director A said the facility will continue to monitor the behavior of Resident 2 and is working on a 30-day notice of discharge.