Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013432	A. BUILDING: _____ B. WING _____	C 05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE CHIPPEWA FALLS ASSISTED CA	115 MARRS ST CHIPPEWA FALLS, WI 54729

(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 05/13/2024, Surveyor conducted 2 complaint investigations and an abbreviated licensure survey at Our House Chippewa Falls Assisted Care. One of the 2 complaints were substantiated. Three deficiencies were identified. Census: 17	N 000		
N 332	83.31(6)(a) Return refunds to resident within 30 days Disbursement of funds. The CBRF shall return all refunds due a resident within 30 days of the date of discharge as required under s. DHS 83.29(3). This Rule is not met as evidenced by: Based on record review and interview, the provider did not return all refunds due to Resident 1 within 30 days of the date of discharge. Findings include: On 01/04/2024, the Department received a complaint alleging the provider would not provide the complainant with a refund after a resident discharged from the facility. The provider is licensed to care for up to 24 residents in the client groups of advanced aged and irreversible dementia/Alzheimer's disease. On 05/13/2024, Surveyor reviewed a roster of discharged residents from the facility. The roster indicated Resident 1 was admitted to the facility	N 332		

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
	0013432	A. BUILDING: _____ B. WING _____	C 05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE CHIPPEWA FALLS ASSISTED CA	115 MARRS ST CHIPPEWA FALLS, WI 54729

(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 332	Continued From page 1 on 10/23/2023 and discharged on 12/06/2023. The discharge reason was documented as: "Higher Level of Care." On 05/13/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 10/23/2023. Resident 1 was sent to the hospital on 11/22/2023 and his/her room was vacated on 11/25/2023. On 05/13/2024 at approximately 2:15 p.m., Surveyor interviewed Administrator A and Regional Director (RD) C. Surveyor asked if Resident 1 was issued a discharge notice and a refund. Administrator A said Resident 1 was not at the facility for 30 days and was not issued a 30-day notice per their admission agreement. Administrator A said Resident 1 had been on hospice, however, family wanted him/her sent to the hospital due to malnutrition. S/he explained Resident 1 had a substantial change in condition. which required more care. Administrator A told Surveyor s/he thought Resident 1 owed the facility money. Surveyor requested to review ledger. On 05/13/2024 at approximately 3:30 p.m., Surveyor reviewed Resident 1's ledger with Administrator A, Assistant Director (AD) B, and RD C and discovered the company did owe Resident 1 a refund of $624.05. This refund was issued on 03/21/2024, which was past 30 days from Resident 1's discharge.	N 332		
N 396	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of	N 396		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013432	A. BUILDING: _____ B. WING _____	C 05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE CHIPPEWA FALLS ASSISTED CA	115 MARRS ST CHIPPEWA FALLS, WI 54729

(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 396	Continued From page 2	N 396		

the residents.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure there were sufficient numbers of employees on a 24-hour basis to meet the needs of all residents.

Resident 2 and Resident 3 required assist of 2 staff members for transferring. The provider did not always schedule 2 staff at all times.

Resident 1 had multiple falls during the night. Staff had to call the facility located next door or emergency services to assist with lifting Resident 1.

Findings include:

On 01/04/2024, the Department received a complaint that alleged there was not adequate staff to meet the residents' needs on the overnight shift.

This provider is licensed to care for up to 24 residents in the client groups of: advanced age and irreversible dementia/Alzheimer's disease.

RESIDENT 2 and RESIDENT 3

On 05/13/2024, Surveyor reviewed the resident roster. The roster identified 2 residents that required 2 staff to assist with transfers, Resident 2, and Resident 3.

On 05/13/2024 at approximately 9:20 a.m., Surveyor interviewed Caregiver D. Caregiver D told Surveyor Resident 2 and Resident 3 required assist of 2 staff to transfer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013432	A. BUILDING: _____ B. WING _____	C 05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE CHIPPEWA FALLS ASSISTED CA	115 MARRS ST CHIPPEWA FALLS, WI 54729

(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 396	Continued From page 3 On 05/13/2024, Surveyor reviewed Resident 2's record. On 05/07/2024, Resident 2 was admitted to the facility. Resident 2's pre-admission assessment, dated 05/07/2024, indicated s/he required 2 team members to assist with ambulation and transfers with the use of a mechanical lift. Resident 2's assessment summary, which had handwritten notes, indicated Resident 2 required "Team Member of 2 and/or sheet method" for repositioning. This was not dated or signed. On 05/13/2024 at approximately 2:15 p.m., Surveyor interviewed Administrator A. Regional Director (RD) C was present. Surveyor asked who completed the handwritten assessment for Resident 2. Administrator A told Surveyor s/he did, along with Assistant Director (AD) B, on 05/07/2024. Resident 2's individual service plan (ISP), with a start date of 05/08/2024, read,, in part: "Resident currently has open areas to the left back tumor area, open areas/shearing to his/her bottom, open area on back upper left thigh and right thigh. Hospice is doing all wound care and will continue wound care while at the community ... Skin Care: Resident/tenant will be turned and repositioned per schedule. On 05/12/2024 at 4:49 a.m., staff documented: "The resident woke up once to be repositioned but otherwise the resident slept the rest of the night." On 05/13/2024 at 5:33 a.m., staff documented: "The resident woke up twice to be repositioned	N 396		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013432	A. BUILDING: _____ B. WING _____	C 05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE CHIPPEWA FALLS ASSISTED CA	115 MARRS ST CHIPPEWA FALLS, WI 54729

(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 396	Continued From page 4 but otherwise the resident slept the rest of the night." On 05/13/2024, Surveyor reviewed the employee schedule. From 05/07/2024 - 05/13/2024 there was only 1 staff member working on the following dates and times: 05/07/2024, 10:00 p.m. - 6:00 a.m. 05/08/2024, 10:00 p.m. - 6:00 a.m. 05/10/2024, 10:00 p.m. - 6:00 a.m. 05/11/2024, 10:00 p.m. - 6:00 a.m. 05/12/2024, 10:00 p.m. - 6:00 a.m. 05/13/2024, 10:00 p.m. - 6:00 a.m. On 05/13/2024 at approximately 3:30 p.m., Surveyor interviewed Administrator A, AD B, and RD C. Surveyor confirmed with Administrator At there were 2 residents that required 2 staff to assist with transfers. Administrator A stated there were. Surveyor asked if they scheduled 2 staff members at all times. Administrator A told Surveyor they did not always have 2 staff on the overnight shift. S/he explained both Resident 2 and Resident 3 were point of rescue if they were in bed and they had negotiated risk agreements. Surveyor explained the requirement to have adequate staff at all times to meet the needs of all the residents. Administrator A confirmed understanding. The provider did not ensure there were 2 staff members scheduled at all times when there were 2 residents that required 2 staff to assist with transfers and repositioning. RESIDENT 1 On 05/13/2024, Surveyor reviewed Resident 1's record. On 10/23/2023, Resident 1 was admitted to the	N 396		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013432	A. BUILDING: _____ B. WING _____	C 05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE CHIPPEWA FALLS ASSISTED CA	115 MARRS ST CHIPPEWA FALLS, WI 54729

(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 396	Continued From page 5 facility with diagnoses of Parkinson's disease and Lewy body dementia. On 10/26/2023, Resident 1 had a visit with his/her nurse practitioner. The assessment/plan read, in part: "[Resident 1] currently is residing at Our House assisted living facility where [s/he] has been a resident for the past 48 hours. [Resident 1] has Parkinson's disease, with underlying Lewy body dementia. [Resident 1] is needing increased assistance with ADLs (activities of daily living), which [his/her] [spouse] is not able to manage on [his/her] own due to [Resident 1's] size and weight ... [Resident 1] currently is ambulatory with the use of a walker, [s/he] needs contact guard assist secondary to instability related to bilateral deformities to [his/her] ankles, as well as significant peripheral neuropathy with loss of sensation to mid shin bilaterally, amputation of numerous toes bilaterally and with noted 3+ bilateral lower extremity edema making walking difficult, recommendation is use of a wheelchair: requiring bariatric size; Ht. (height) 6 feet 4 inches, Wt. (weight) 305 # (pounds) ..." Resident 1 had multiple falls from his/her admission until s/he went to the hospital on 11/22/2023 and was discharged from the facility. Staff documented multiple entries that they had to call emergency medical technicians (EMTs) for lift assist or staff from the community based residential facility (CBRF) located next door to assist with Resident 1. 11/01/2023, incident time 5:15 p.m. - Resident 1 was found on the floor. The report read, in part: "EMT's called to get resident off the floor safetly [sic]. Staff tried to get resident off the floor but was unsuccessful."	N 396		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013432	A. BUILDING: _____ B. WING _____	C 05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE CHIPPEWA FALLS ASSISTED CA	115 MARRS ST CHIPPEWA FALLS, WI 54729

(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 396	Continued From page 6 11/06/2023, incident time 2:25 a.m. - Resident 1 was found on the floor. The report read, in part: "The RCA (Resident Care Assistant) called the memory care next door to get a lift assist and each of the RCAs came over one at a time. RCAs were not successful at getting the resident up and four attempts were made. The RCA called EMTs for a lift assist and it took three EMTs to get the resident up and into [his/her] recliner." 11/07/2023, incident time 8:30 p.m. - Resident 1 found on the floor. The report read, in part: "Went and got my coworker and tried to get [him/her] up did rom (range of motion) and vitals ..." Emergency services were notified at 8:42 p.m. 11/08/2023 at 4:45 a.m., staff documents: "The RCA had to call the memory care unit next door when the resident woke up needing to go to the bathroom because [s/he] was unable to stand up long enough with one person ..." 11/11/2023, incident time 11:30 p.m. - Resident 1 found on the floor. The report read, in part: "call non emergancy [sic] number for lift assist 11:32 am" 11/11/2023 at 4:32 a.m., staff documented: "The resident was awake on and off until about 1 am, RCA had to call next door to help boost the resident in bed since [s/he] was sliding [him/herself] out of it ..." 11/14/2023, incident time 6:00 a.m. - Resident 1 found on the floor. The report read, in part: "4 staff assisted [him/her] into wheelchair." 11/15/2023 at 4:53 a.m., staff documented: "The resident returned from the hospital around 2 am. It took three people to get the resident from the	N 396		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013432	A. BUILDING: _____ B. WING _____	C 05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE CHIPPEWA FALLS ASSISTED CA	115 MARRS ST CHIPPEWA FALLS, WI 54729

(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 396	Continued From page 7 car and into bed ..." 11/16/2023, incident time 12:40 a.m. - Resident 1 found on the floor. The report read, in part: "ROM preformed [sic], called hospice, called POA (power of attorney), and non emergency emts [sic]." 11/18/2023, incident time 11:00 p.m. - Resident 1 found on the floor. The report read, in part: "Next door unit was called at 11:02 pm for a successful lift assist and the RCA was able to get the residewnt [sic] into bed again ..." On 11/22/2023, Resident 1 went to the hospital and did not return to the facility. On 05/13/2024, Surveyor reviewed the employee schedule for November 2023. From 11/01/2023 - 11/22/2023, there was only 1 staff scheduled on 11/02/2024 - 11/19/2024 and 11/21/2024 from 10:00 p.m. - 6:00 a.m. On 05/13/2024 at approximately 3:30 p.m., Surveyor interviewed Administrator A, AD B, and RD C. AD B told Surveyor s/he was aware Resident 1 was a large person prior to admitting Resident 1. S/he said Resident 1 was ambulating independently at home prior to his/her admission. S/he explained Resident 1 had a significant change in condition after s/he was admitted. The provider did not always staff at least 2 staff members to assist with Resident 1 after s/he had a change in condition. Staff had to call EMTs for lift assist and call the CBRF located next door to assist with Resident 1.	N 396		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013432	A. BUILDING: _____ B. WING _____	C 05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE CHIPPEWA FALLS ASSISTED CA	115 MARRS ST CHIPPEWA FALLS, WI 54729

(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 8	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, interview, and record review, the provider did not ensure combustible materials were not placed within 3 feet of the boiler. Findings include: The provider is licensed to care for up to 24 residents in the client groups of advanced age and irreversible dementia/Alzheimer's. On 05/13/2024, Surveyor reviewed the provider's safety reports. On 01/12/2023, the fire department conducted an inspection and noted violation 10.19.5.1 Combustible material shall not be stored in boiler rooms, mechanical rooms, or electrical equipment rooms. On 05/13/2024 at approximately 3:50 p.m., Surveyor observed the boilers in the basement of the facility with Assistant Director (AD) B. There were multiple combustible materials, including: cardboard, paper, old filters, and a box of new filters located within 3 feet, directly under the boiler. (Photo 1). AD B told Surveyor those items were not there the last time s/he inspected the basement, which was the previous week. The provider did not ensure combustible materials were not placed within 3 feet of their boiler.	N 507		