

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0013432	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 07/18/2025
NAME OF PROVIDER OR SUPPLIER OUR HOUSE CHIPPEWA FALLS ASSISTED CA		STREET ADDRESS, CITY, STATE, ZIP CODE 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 07/18/2025, Surveyor conducted a complaint and verification visit at Our House Chippewa Falls Assisted Care. The complaint was unsubstantiated. No deficiencies were identified. Census: 20 Under statutory provisions of Wis. Stat. ch. 50, a \$200 revisit fee is being assessed.	{N 000}		

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

TITLE

(X6) DATE