

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0013445	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/02/2026
NAME OF PROVIDER OR SUPPLIER OUR HOUSE WI RAPIDS ASSISTED CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2941 16TH ST SOUTH WISCONSIN RAPIDS, WI 54494		
(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 06/02/2026, Surveyor conducted two complaint investigations at Our House WI Rapids Assisted Care, a Community-Based Residential Facility (CBRF) in Wisconsin Rapids, WI. No deficiencies identified. Two of two complaints unsubstantiated. Census: 18	N 000		

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

TITLE

(X6) DATE