STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013426	A. BUILDING: _____ B. WING _____	C 09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE RICE LAKE MEMORY CARE	413 E SOUTH STREET RICE LAKE, WI 54868

(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 09/23/2025, Surveyors conducted an abbreviated licensure survey, a self-report investigation, and a complaint investigation at Our House Rice Lake Memory Care. Data was collected through 09/29/2025. One of 3 complaints were substantiated. One violation was identified. Census: 20	N 000		
N 358	83.32(3)(n) Rights of Residents: Safe environment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents ' conditions or disabilities. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure residents had the right to a safe environment. Findings include: On 06/19/2025, the Department received a self-report from the provider regarding Resident 1 falling on 05/29/2025 and sustaining visible injuries. The report documented a second fall, which occurred on 06/17/2025 in which Resident 1 had fallen down a set of stairs due to 2 doors	N 358		

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

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being left unlatched.

On 07/17/2025, the Department received a complaint regarding an unsafe environment that was hazardous to residents' conditions and/or disabilities.

On 09/23/2025, at approximately 9:53 AM, Surveyor interviewed Executive Director (ED) A regarding Resident 1's fall. ED A stated Resident 1 had fallen a few months prior and had sustained injuries on the left side of his/her face. ED A stated Resident 1's death in July 2025 was not due to his/her fall down the basement stairs, and that his/her fatal injuries were from the first fall. ED A stated that when Resident 1 had fallen down the basement stairs, s/he had landed on his/her right side and the injuries found at the hospital were on his/her left side. ED A stated that when Resident 1 had fallen on 05/29/2025, his/her family elected not to have him/her medically assessed and did not call for emergency medical services (EMS). ED A stated Resident 1's family had wanted comfort cares only, and that provider staff had encouraged them to have Resident 1 medically evaluated. ED A stated Resident 1 declined after the first fall, and s/he did not believe that Resident 1 died from the second fall.

On 09/23/2025, Surveyors reviewed Resident 1's records. Resident 1's records indicated s/he had fallen 2 times with injuries on 05/29/2025 (once at approximately 1:30 AM and once at approximately 7:20 AM) and 1 time with injuries on 06/17/2025 at approximately 1:40 PM. Resident 1 was diagnosed with dementia, according to his/her individual service plan (ISP). An incident report for Resident 1, dated 05/29/2025, described a fall with injuries. The

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report read, in part:

"While doing checks, I found the resident laying [sic] on the floor with their head by their closet, feet pointed twards [sic] their dresser, with their walker folded ny [sic] their legs. Resident also had wounds above their left eye, left side of lips were very swollen and a very bloody nose. The resident had a 4-5 inch pool of blood formed on the floor in front of them ...Bruise found: Upper lip on left side is bruised, as well as left eye, Other: resident has a very bad bloody nose, Skin Tear: Resident has a skin tear (rug burn) above their left eye brow [sic], Swelling: Residents [sic] left eye is swollen, the upper eye lid [sic] is more swollen than the lower..."

An incident report for Resident 1, dated 05/29/2025, described a fall with injuries. The report read, in part:

"Resident was unable to communicate with staff as to exactly what happened all [sic] the resident would say is please help get me up, and that [s/he] is trying to go down stairs ...When RCA's [Resident Care Assistants] [sic] were walking past residents [sic] room they saw resident on the floor infront [sic] of [his/her] bed where they noticed that [his/her] nose was again bleeding and resident was very aggitated [sic] and confused [sic] telling staff [s/he] had to go down stairs [sic] ...Bruise found: bruise on [his/her] nose and on [his/her] left eye, swelling of the face, an abrasion on the back of the head, bloody nose, Other: swollen left eye, Pain: resident stated that [his/her] pain level was at about a 6, Swelling: swelling of [his/her] left eye/cheek and upper lip on the left side ..."

An incident report for Resident 1, dated

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06/17/2025, described a fall with injuries. The report read, in part:
"[Assistant Director (AD) B] and [hospice nurse] were in the hallway next to the kitchen entrance door and near basement door when we heard a loud bang coming from the basement. [AD B] and [hospice nurse] had looked down the basement stairs and seen resident at the bottome [sic] of the first set of stairs laying [sic] sideways still part way [sic] in [his/her] wheel chair [sic] ...Abrasion to left side of face, bloody nose, skin tear to right elbow, scrape on right knee, and scrape on lower left leg, and bump on back of head ...[AD B] and [hospice nurse] called EMS [emergency medical services] to come assess resident, EMS [emergency medical services] obtained vitals, EMS [emergency medical services] assisted with getting resdient [sic] back up the stairs and then transported resident to [sic] hospital to be further evaluated ...Team members will ensure all kitchen and basement doors are latched and locked behind them ..."

Progress notes for Resident 1 from 05/29/2025 included the following:

- A note at 3:49 AM read, in part, "Resident had an unwitnessed fall with injuries at 130am [sic], hospice arrived at 3;45am [sic] to check the resident over. Hospice stated that there wasn't much they could do and told staff it was safe to put the resident in bed to sleep ..."
- A note at 4:30 AM read, in part, "EMERGENCY SERVICES NOTIFIED: No ..."
- A note at 11:52 AM read, " ...family was here and decided to not send resident to er [emergency room] at this time for further evlaution [sic] and only wanted to do comfort cares at this time ..."

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An "After Visit Summary" report for Resident 1, dated 06/17/2025, read, in part:

"Reason for Visit
Trauma
Diagnoses:
- Traumatic Brain Compression Without Herniation Initial Encounter
- Abrasion Face Initial
- Fracture Orbital Floor Closed Initial Left
- Fracture Zygomatic Closed Initial Left
- Fracture Maxillary Sinus Closed Subsequent
- Secondary Malignant Neoplasm Brain"

A coroner's report, dated 07/11/2025, read, in part:

"...Date of death 07/11/2025...Suspected COD [cause of death] is Fall Trauma, Cancer of the left kidney with metastsis [sic] of brain and lung ..."

At approximately 11:00 AM and 1:00 PM, Surveyors observed that the provider's kitchen had a back entrance that led into a storage room, which was connected both to the basement and a hallway used by residents. The backdoor to the kitchen storage area led into the resident hallway, and was typically locked from the outside.

At approximately 11:00 AM, Surveyor interviewed AD B, who stated a key was needed to get into the basement. AD B stated on 06/17/2025, Caregiver C had propped open the basement door.

At approximately 5:00 PM, ED A sent Surveyors an email which included emergency department records for Resident 1. The narrative from the emergency department report, dated 06/17/2025, read, in part:

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N 358	Continued From page 5 "CHIEF COMPLAINT/REASON FOR VISIT Trauma (Fell in wheelchair down approx [approximately] 12 steps at [provider name]; staff reports that it was unwitnessed and they found [him/her]; unsure of LOC [level of consciousness]) ..." The provider did not ensure residents had the right to live in a safe environment.	N 358		