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 _____	R-C 01/28/2026

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 01/20/2026, Surveyor conducted a verification visit and complaint investigation at Our House Rice Lake Memory Care. Data was collected through 01/28/2026. The citation from Statement of Deficiency (SOD) T8KY11, dated 09/29/2025, was corrected. One of 2 complaints was substantiated. One new violation was identified. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 19.	{N 000}		
N 426	83.38(1)(b) Supervision. 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: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on record review and interview, the CBRF (community based residential facility) did not provide supervision appropriate to the resident's needs.	N 426		

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

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N 426	Continued From page 1 Findings include: On 11/20/2025, the Department received a complaint regarding resident care and supervision. The provider is licensed to care for 24 residents in the client groups: advanced aged and irreversible dementia/Alzheimer's disease. On 01/20/2026 from 1:35 PM to 2:05 PM, Surveyor interviewed Caregiver A who stated Resident 1 enrolled in hospice after admission. Caregiver A stated Power of Attorney (POA) B told him/her that Resident 1 fell often at his/her previous placement. Caregiver A stated Resident 1 was kept where they could see him/her, that s/he wandered a lot, and when s/he was in his/her room the door was kept open. Caregiver A stated Resident 1 had a fall resulting in a broken hip and after that s/he was sent to a new facility for rehabilitation and had since passed away. Caregiver A stated new interventions were implemented after each fall. From 2:25 PM to 2:50 PM, Surveyor interviewed Caregiver C who stated Resident 1 was sweet and easy to help. Caregiver C stated Resident 1 walked around the house often and liked to hang on the hallway railings. Caregiver C stated there were fall interventions in place. At approximately 2:55 PM, Surveyor interviewed Assistant Director (AD) D who stated fall interventions were added to Resident 1's individualized service plan (ISP) after each fall. On 01/26/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 10/15/2025 and discharged on 11/15/2025. Resident 1 was	N 426		

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N 426	Continued From page 2	N 426		

diagnosed with dementia with agitation and sleep difficulties. Resident 1 had a POA.

Resident 1's ISP dated 01/26/2026 included the following:
- ..."Ambulation: Independent ...resident is considered a fall risk.
- ...Falls ...occur on a weekly basis ....
- ...Behavior: Sexually Inappropriate: Maximum Supervision (daily)..New Intervention ...10/24/2025 resident is placed on line of site - team member that is in charge of line of sight will wear a scrunchie to determine who is in charge of residents line of sight ..."

Surveyor reviewed documents titled Resident Incident Reports that included 13 incident reports, 10 fall reports and 3 resident-to-resident reports:
-10/16/2025 at 10:15 AM: unwitnessed fall, sent to ER due to complaints of head and neck pain. Intervention: grippy socks requested from POA,
-10/17/2025: 9:00 PM: resident to resident, mistook [fe/male] resident for significant other, took hand and followed other resident into his/her room. Intervention: offer a stuffed animal to hold for comfort,
-10/22/2025 9:50 PM: in another [fe/male] resident room resident to resident, Resident 1 was in other resident's room and touching his/her legs. New interventions: engage in activities,
-10/23/2025 9:45 PM: unwitnessed fall on floor in dining room, resident said s/he was looking for something. No ER (emergency room). Chair was knocked over. New intervention: help to ensure s/he uses chair properly,
-10/23/2025 9:50 PM: resident to resident: looking for significant other and got into bed with other resident and began to take off clothes. New intervention: put name outside bedroom door,
-10/26/2025 10:00 AM: unwitnessed fall, found on

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floor on hands and knees, EMS (emergency medical services) called because hit head, no ER transfer. Resident does not sleep. New intervention: use hallway rail,
-10/27/2025 11:20 PM: unwitnessed fall: no injury found on right side in bedroom, could not explain what occurred. EMS arrived at 11:40 not sent out per POA. New intervention: offer to watch movie to help relax,
-10/28/2025 2:49 PM: unwitnessed fall in activity room by couch, abrasion to right side of head, sent to ER. New intervention: assist with sitting on couch correctly,
-11/06/2025 2:30 AM: unwitnessed fall but POA refused to send out. Resident found lying in fetal position in activity room, with a small cut on head. New intervention: encourage resident to sleep in bed,
-11/07/2025 5:30 AM: unwitnessed fall sent to ER, was found on floor in bedroom by bathroom with blood all over, went to ER. New intervention: night light requested,
-11/08/2025 7:50 AM: unwitnessed fall in activity room, on floor on buttocks attempting to lie down, not sent out as head pain was most likely from fall the previous day.
New intervention: hospice referral,
-11/12/2025 6:00 AM: unwitnessed fall, found covered in blood with large cut on head. EMS arrived 6:07 AM and was taken to ER. New intervention: offer for resident to sleep on couch instead of chair,
-11/15/2025 12:20 AM: unwitnessed fall sent to ER, due to pain in head. Discomfort observed in hip area. Called hospice, administered morphine. New intervention: alarms requested for bed.

On 01/28/2026 from 1:10 PM to 1:19 PM, Surveyor interviewed Caregiver E who stated Resident 1 was always kind and was always

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N 426	Continued From page 4 walking. Caregiver E stated we tried to distract him/her with activities because s/he was a fall risk and felt there were enough interventions. Surveyor asked what 'line of sight' meant or if s/he witnessed staff wearing a scrunchie designating them as the lead staff to keep an eye on Resident 1. Caregiver E stated s/he was never informed to always keep eyes on Resident 1. On 01/28/2026 from 1:40 PM to 2:54 PM, Surveyor interviewed AD D, Administrator F, and Executive Director (ED) G. Administrator F stated that Resident 1's admission was rushed as POA B wanted to move Resident 1 out of his/her current placement. Administrator F stated there was a delay with admission paperwork and s/he was unable to reach his/her previous placement and was not aware of his/her high fall history. Administrator F stated there were always at least 2 staff working. Surveyor asked Administrator F what line of sight meant. Administrator F stated it meant a team member knew where Resident 1 was always located. Surveyor inquired if Resident 1 was line of sight was implemented on 10/24/2025, how did s/he have 8 falls. Administrator F stated line of site depended on staffing. The provider did not ensure Resident 1 had supervision appropriate to his/her needs.	N 426		