STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013430	A. BUILDING: _____ B. WING _____	C 04/24/2026

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OUR HOUSE EAU CLAIRE MEMORY CARE	733 W HAMILTON AVE EAU CLAIRE, WI 54701

(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 04/14/2026, Surveyor conducted six complaint investigations at Our House Eau Claire Memory Care. Data collection continued through 04/24/2026. Three of 6 complaints were substantiated. Five deficiencies were identified. One of 5 deficiencies was a repeat deficiency. See Statement of Deficiency QDKK12, dated 09/09/2021. Census: 16	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation.	N 158		

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

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N 158	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the provider did not report the incident to the department within 7 days from the date the CBRF knew or should have known about the abuse. This is a repeat deficiency. See Statement of Deficiency QDKK12, dated 09/09/2021. Findings include: On 01/06/2026 and 01/26/2026, the Department received complaints regarding resident care and follow-up for allegations of caregiver misconduct. On 03/16/2026, the provider submitted a Misconduct Incident Report (MIR) for an incident with a discovery date identified as 01/19/2026. The MIR documented the dates of the actual incidents were unknown for allegations of abuse by Caregiver A and included the following information: Caregiver A reportedly dropped residents causing significant injury, grabbed residents by the wrists causing bruising, yelled at residents when they asked for more food and did not give them more food, and transported a resident back to his/her room where there was an unreported fall, resulting in a fractured arm. The MIR further stated Caregiver A had been suspended and terminated after the investigation. The MIR listed 3 affected residents: Resident 2, Resident 4 and Resident 5. On 04/14/2026, at approximately 9:45 AM, Surveyor requested to review the provider's documented investigations completed for allegations of caregiver misconduct for the last six months. On 04/14/2026, Surveyor requested to review	N 158		

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N 158	Continued From page 2 Caregiver A's payroll records for January 2026. On 04/16/2026 at approximately 8:15 AM, Residence Director (RD) C sent Caregiver A's payroll record which documented the following dates and times worked: 01/01/2026-2:05 PM-10:07 PM 01/02/2026 3:01 PM-10:00 PM 01/05/2026 1:21 AM-2:05 PM 01/06/2026 5:56 AM-2:18 PM 01/07/2026 2:53 PM-9:10 PM 01/08/2026 5:13 PM-2:00 PM 01/10/2026 1:59 PM-9:54 PM 01/11/2026 2:02 PM-10:00 PM 01/12/2026 10:00 PM - 12:00 AM 01/13/2026 12:00 AM-6:00 AM 01/14/2026 10:00 PM-12:00 AM 01/15/2026 12:00 AM-6:00 AM 01/15/2026 7:41 AM-3:34 PM On 04/16/2026, at 3:17 PM, Residence Director (RD) C confirmed via email Caregiver A was suspended on 01/19/2026, and was terminated on 01/29/2026. On 04/20/2026, at approximately 2:30 PM, Assistant Director (AD) B stated via email, "The facility conducted an internal investigation into [Caregiver A]'s actions. The allegations were substantiated, and [his/her] employment was terminated due to physical abuse of a resident." On 04/21/2026 at approximately 2:00 PM, AD B provided clarification Caregiver A was terminated for physical abuse of Resident 4. Cross Reference N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 158		

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N 214	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure the administrator supervised the daily operation of the facility in a way that ensured residents received proper care and treatment and their health, safety, and rights were protected. Residence Director (RD) F did not follow up with concerns related to injuries of unknown origin, did not initiate an investigation into caregiver misconduct allegations (Caregiver A), did not respond or monitor resident health care concerns, and directed staff to falsely document charting for a resident (Resident 2) that had bruising on his/her arm. Resident 2 was sent out 2 days after staff charted on the bruise and diagnosed with a fracture to the proximal portion of the right humerus. RD F was suspended on 01/19/2026 pending investigation for failing to respond to resident care concerns and professionalism. Several attempts	N 214		

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N 214	Continued From page 4 were made to contact RD F via phone throughout the investigation. The last attempt was made on 02/02/2026. RD F did not respond and did not return to work. Findings include: The provider is licensed to care for 20 residents in the client groups advanced aged, and irreversible dementia/Alzheimer's disease. The Department received 6 complaints related to resident care and oversight of resident care. On 04/14/2026 at approximately 9:30 AM, Surveyor interviewed RD C and Assistant Director (AD) B and asked who was responsible for the daily operations of the facility. RD C stated s/he was recently hired and responsible for the day-to-day operations. AD B stated RD F was previously responsible and was no longer employed. Surveyor requested to review documentation of all investigations completed within the last 6 months. On 04/14/2026 at approximately 12:45 PM, Surveyor interviewed Resident 3's spouse and power of attorney (POA), POA E. POA E stated s/he had concerns and voiced them to Residence Director (RD) F (Administrator) of bruising on Resident 3's neck and temple. POA E stated RD F responded that s/he would investigate the bruising. POA E stated RD F did not take appropriate action so POA E contacted the hospice nurse, the county, and Vice President (VP) of Operations G, as RD F did not respond to his/her concerns. POA E stated that once s/he notified VP of Operations G, RD F was suspended as several other concerns were not being addressed by RD F.	N 214		

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N 214	Continued From page 5 Surveyor reviewed an investigation summary provided by AD B, dated 01/16/2026, prepared by Vice President (VP) of Operations G for "Management Complaints - Failure to Follow Up on Concerns." The report documented the following timeline: -01/16/2026 at 5:46 PM: VP of Operations called Resident 3's POA E in response to an email request from POA E. POA E was upset felt Resident 3 was being abused and was reported to RD F on 01/12/2026 and did not feel s/he responded to his/her concerns. POA E further reported to VP of Operations that s/he felt Resident 3's hospice nurse was being retaliated against by RD F after reporting concerns to RD F that RD F "sweeps it under the rug." -01/19/2026 at 8:57 AM: RD F called VP of Operations. VP of Operations informed RD F that the hospice nurse would be in house and expected RD F to treat him/her with respect and professionalism. RD F stated there were many issues with the hospice nurse and s/he felt s/he was telling staff and families that Caregiver A abuses the residents and was making sexual comments. RD F stated s/he had not witnessed it and stated it had not been reported to him/her. -01/19/2026 at 2:47 PM: VP of Operations received a voicemail from Caregiver H regarding concerns. Director D called Caregiver H and requested a statement. A summary of the statement submitted by Caregiver H included concerns with residents not properly cared for, staff failing to complete duties, and lack of action from management when issues were reported. Caregiver H stated that s/he was brought into RD F's office on 01/19/2026 after Resident 3's	N 214		

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spouse contacted VP of Operations regarding care concerns. Caregiver H stated RD F instructed him/her to write a late entry in Resident 2's record that staff had witnessed him/her running into a doorframe. Caregiver H stated s/he did not witness it and felt uncomfortable documenting information that was not true. Caregiver H further states several employees and family members had voiced concerns to RD F regarding Caregiver A and resident injuries, but no action was taken by RD F.

-01/19/2026 at 6:50 PM: RD F was suspended, pending investigation.

-01/20/2026 11:09 AM - 3:00 PM: VP of Operations interviewed 5 caregivers. Staff interviewed reported they reported resident care concerns to RD F, did not feel comfortable going to management, and felt their concerns were not addressed.

-01/20/2026 at 11:36 AM: VP of Operations interviewed hospice nurse (RN) H. RN H reported s/he has reported Caregiver A to RD F for being rough with residents and heard from another caregiver that Caregiver A told Resident 5 that s/he would "slap the [expletive] out of [him/her]." RN H stated RD F and AD B were aware of complaints but did not take appropriate action. RN H stated s/he was receiving several complaints from family members because they did not feel comfortable going to RD F for fear of retaliation.

-01/21/2026: VP of Operations interviewed additional staff who reported they were directed by RD F not to chart resident behaviors or falls.

-On 01/23/2026: RD F's personnel file was

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reviewed. RD F was hired on 08/16/2021. Reviewed company policies on 08/16/2021. RD F received a handbook on 08/16/2021. RD F received corrective action on 03/22/2022 for unprofessional behavior for gossiping, making unprofessional statements to team members such as sexual statements and threatening to fire them if reporting concerns to management, and failed to investigate a HIPAA violation. RD F received a corrective action on 12/06/2024 for professionalism as s/he was making negative statements to team members about his/her supervisor, having inappropriate discussions with team members, failing to ensure team members followed a resident's diet and Hoyer lift, and signing an inappropriate song in the presence of residents and family members. RD F received corrective action on 10/08/2025 for failing to ensure adequate staffing was available at the location.

-01/23/2026: VP of Operations attempted to contact RD F at 8:23 AM and 2:38 PM, but RD F did not respond.

The provider's investigation documented the following actions would be taken upon completion of the investigation related to RD F:

- "[RD F] was considered a NCNS (no call no show) and would not respond to be interviewed for concerns related to the investigation."

- "Report [RD F] for caregiver misconduct for failure to follow-up on concerns related to residents and investigate caregiver misconduct."

The provider's investigation also documented re-training, and education would be provided to staff on proper documentation of falls and

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behaviors and ensure tasks are created to track toileting tasks. The investigation also reported Caregiver A was no longer employed as a result of caregiver misconduct.

On 03/16/2026, the provider submitted a Misconduct Incident Report (MIR) for an incident with a discovery date identified as 01/19/2026. The MIR documented the dates of the actual incidents were unknown for allegations of abuse by Caregiver A and included the following information: Caregiver A reportedly dropped residents causing significant injury, grabbed residents by the wrists causing bruising, yelled at residents when they asked for more food and did not give them more food, and transported a resident back to his/her room where there was an unreported fall, resulting in a fractured arm. The MIR further stated Caregiver A had been suspended and terminated after the investigation. The MIR listed 3 affected residents: Resident 2, Resident 4 and Resident 5.

On 04/14/2026, Surveyor reviewed resident records for Resident 2, Resident 3 and Resident 4.

Resident 2 had an admission date of 10/06/2021 and had the following diagnoses: major neurocognitive disorder with behavioral disturbance, and dementia in other diseases classified elsewhere with behaviors.

Surveyor reviewed staff charting documentation for Resident 2:

-01/17/2026 at 1:55 PM: "Noticed a huge bruise on [his/her] right upper arm."
-01/18/2026 at 1:29 PM: "Resident bruising is still purple and swollen.

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N 214	Continued From page 9 -01/19/2026 at 10:32 AM: "Late Entry for 1/15/2026 9:40 AM: resident was witnessed stumbling into the door frame from hall to living room hitting [his/her] right shoulder. Watch for bruising, etc." -01/19/2026 at 1:49 PM: "Bruising is significant and appears to be running down [his/her] arm. Per hospice arm could potentially be broken [sic] needs to hear back from POA for xray [sic] [his/her] morphine will be coming today." -01/19/2026 at 8:54 PM: "Resident went out to get [his/her] arm checked out and got back pretty late. [S/he] had a quick bite to eat before staff helped [him/her] get ready for bed ..." Resident 2 passed away on 02/08/2026. Resident 3 had an admission date of 06/12/2024 and had the following diagnoses: dementia, sensorineural hearing loss, bilateral, anxiety disorder, and major depressive disorder. Surveyor reviewed staff charting documentation for Resident 3: -RD F charted on 01/14/2026 at 3:20 PM: "Director was made aware of yellow bruising on both sides of residents [sic] face. Bruising is yellow in nature and appears to be bleeding from the goose egg from a previous fall. Bruise investigation has been started." Resident 4 had an admission date of 01/22/2021 and had the following diagnoses: dementia without behavioral disturbance, major depressive disorder, anxiety disorder, and history of falls. Surveyor reviewed staff charting documentation for Resident 4:	N 214		

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N 214	Continued From page 10 -RD F charted on 01/12/2026 at 2:56 PM: "Late entry for 01/05/2026 at 9:30 AM: Resident's Poa (power of attorney) [sic] notified director via text that resident has a bruise of unknown origin on [his/her] left wrist. Resident stated [s/he] had started to fall in the bathroom as staff tried to transfer [him/her] and [his/her] arm was grabbed when they caught [him/her] from falling." Surveyor reviewed the investigation completed by RD F. The investigation was completed with a date of 01/06/2026, with a discovery and notification date of 01/03/2026. Based on an assessment of the bruise, the investigation documented that the bruise was approximately 7-10 days old. The report stated that a staff member (Caregiver A) grabbed the arm of a resident to prevent a fall. On 04/14/2026 at approximately 2:25 PM, Surveyor interviewed Assistant Director (AD) B if the bruises listed above were monitored. AD B stated, "If it's not in the progress notes (staff charting), it wasn't documented or charted on." No additional entries were available in staff charting notes to document the bruises were monitored. On 04/21/2026 at approximately 3:40 PM, Surveyor emailed AD B and asked if Resident 2, Resident 4 and Resident 5 had guardians and whether or not they were notified of the abuse. On 04/22/2026 at approximately 12:30 PM, AD B stated via email, "[Resident 4] is the main one [his/her] POA is the one that brought the bruise to [RD F]'s attention...I am clarifying with the person who actually did the investigation to find out if families were notified."	N 214		

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N 214	Continued From page 11 On 04/24/2026 at approximately 10:15 AM, AD B informed Surveyor via email, "...[Resident 2]'s family was notified on 1.26.26 when [s/he] came in to ask about a bill. [Resident 5]'s family was not notified." On 04/27/2026, Surveyor reviewed the Department's record for a MIR submission for RD F. AD B submitted an MIR electronically on 04/16/2026 at 2:51 PM; approximately 83 days after RD F was investigated for management complaints and failure to follow-up on concerns brought to his/her attention. Cross Reference N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse and Neglect	N 214		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12.	N 219		

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N 219	Continued From page 12 This Rule is not met as evidenced by: Based on record review and interview, the provider did not complete a caregiver background check (CBC) for 1 of 1 staff sampled (Caregiver A). This is a repeat deficiency. See Statement of Deficiency (SOD) QDKK12, dated 09/09/2021. Findings include: On 01/06/2026, the department received a complaint alleging caregiver misconduct. On 04/14/2026, Surveyor reviewed employee records. A complete CBC consists of 3 components: 1. A background disclosure (BID) filled out by the employee, 2. A criminal history record search from the Department of Justice (DOJ), 3. The Governmental Findings Report (GRF) letter to alert the employers to findings, restrictions and licenses from the Department of Health Services (DHS). Caregiver A was hired on 11/26/2025. Caregiver A's record did not include a BID. At approximately 3:30 PM, Surveyors interviewed Assistant Director (AD) B, Residence Director (RD) C and Director D. Director D acknowledged they did not have Caregiver A's BID and stated it must have gotten misplaced.	N 219		
N 427	83.38(1)(c) Leisure time activities. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the	N 427		

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(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 427	Continued From page 13 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: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents. This Rule is not met as evidenced by: Based on observation and interview, the provider did not provide a daily activity program to meet the interests and capabilities of the residents. Findings include: On 04/06/2026, the department received a complaint alleging the facility was not providing activities for residents. On 04/14/2026, at approximately 10:00 AM, Surveyor toured the facility and did not observe an activity schedule posted. At approximately 10:30 AM, Surveyor entered Resident 1's room. Resident 1 was sitting in his/her recliner and had 2 visitors. When asked how things were going, they stated the home could offer more activities, and residents did not really do anything. The visitors stated Resident 1 would be happier if there were more activities for Resident 1 to participate in. At approximately 3:30 PM, Surveyors interviewed	N 427		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013430	A. BUILDING: _____ B. WING _____	C 04/24/2026

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N 427	Continued From page 14 Assistant Director (AD) B, Residence Director (RD) C and Director D. When asked about the activity schedule, AD B stated it was ordered but had to be re-ordered. When asked if they had staff designated to plan activities, AD B stated they did but the staff responsible for that task also worked on the floor. AD B stated they had a staff member tasked to come in to offer activities twice per week.	N 427		
N 489	83.44(2)(a) Rooms clean and free from odors. The CBRF shall keep all rooms clean and shall make reasonable attempts to keep all rooms free from odors. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure resident rooms were clean and free from odors. Findings include: On 04/14/2025, at approximately 10:20 AM, Surveyors observed Resident 1's room. Surveyors observed a pungent urine-like odor when entering Resident 1's room. Surveyor did not observe the physical source of the odor such as soiled items or visible waste. Surveyor entered Resident 1's bathroom which was considerably warmer than the rest of his/her room. There was a pile of what appeared to be soiled laundry laying in the shower area. It was undetermined if that was the source of the smell or if heat was a contributing factor. On 04/14/2026 at approximately 10:23 AM,	N 489		

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N 489	Continued From page 15 Surveyor interviewed Caregiver I after s/he accompanied Resident 1 to his/her room. Caregiver I stated the flooring and carpet was not replaced prior to Resident 1's admission and staff were told by management to carpet clean and scrub the bathroom. Caregiver I stated they could not get the urine odor out from the previous resident who had incontinence behaviors. Surveyor asked Caregiver I about the soiled laundry in the shower. Caregiver I stated they were short staffed and were "down 1 today." At approximately 10:30 AM, Surveyor returned to Resident 1's room. Resident 1 was sitting in his/her recliner with 2 visitors. One of Resident 1's visitors used Resident 1's bathroom during interview. When asked if they had any concerns, the visitors acknowledged the odor and stated there was a lot of laundry in the bathroom. One of Resident 1's visitors stated they did not approve of the amount of laundry in the bathroom. At approximately 3:22 PM, Surveyors returned to Resident 1's room with Assistant Director (AD) B, Residence Director (RD) C, and Director D. AD B, RD C and Director D acknowledged the strong odor and expressed it was unpleasant. AD B stated the previous resident who occupied Resident 1's room had a history of uncontrolled urination, and the urine may have affected the flooring. AD B stated the provider planned to update the flooring in Resident 1's room.	N 489		