

Wisconsin Department of Health Services

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>0013381</b>                   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R-C<br/>07/07/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OUR HOUSE JANESVILLE MEMORY CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4333 PHEASANT RUN RD<br/>JANESVILLE, WI 53546</b> |                                                                                                                          |                                                                |
| (X4) ID<br>PREFIX<br>TAG                                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                       |
| {N 000}                                                                     | <p>Initial Comments</p> <p>On 07/07/2026, Surveyor conducted a verification visit and 2 complaint investigations at Our House Janesville Memory Care, a CBRF in Janesville.</p> <p>There were no deficiencies identified. Two deficiencies from Statement of Deficiency (SOD) O8Y511, dated 03/31/2026 were corrected.</p> <p>The two complaints were unsubstantiated.</p> <p>Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed.</p> <p>Census: 10</p> | {N 000}                                                                                       |                                                                                                                          |                                                                |

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

TITLE

(X6) DATE