STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017729	A. BUILDING: _____ B. WING _____	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTEGRICARE RICE LAKE	**315 E ST PATRICK ST 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 05/26/2026, Surveyor conducted a standard licensure survey at Integricare Rice Lake. Data was collected through 05/27/2026. Five violations were identified. Census: 8.	N 000		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 employees reviewed had obtained documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating they had been screened within 90 days before the start of employment for clinically apparent communicable disease. Findings include:	N 220		

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

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N 220	Continued From page 1 The provider is licensed to care for 8 residents in the client groups advanced aged, developmentally disabled, and emotionally disturbed/mental illness. On 05/26/2026, Surveyor reviewed the employee records of Caregiver A and Caregiver B -Caregiver A, hired 10/07/2019, did not have communicable disease screening documentation. -Caregiver B, hired 04/07/2026, did not have communicable disease screening documentation. At approximately 12:33 PM, Surveyor interviewed Licensee C who stated " ...I'll be honest ...don't think we do those." Licensee C stated none of their caregivers were screened for communicable disease. The provider did not screen 2 of 2 employees for communicable disease.	N 220		
N 404	83.37(1)(e) Medication regimen, administration review. Medication Regimen Review. 1. If residents ' medications are administered by a CBRF employee, the CBRF shall arrange for a pharmacist or a physician to review each resident ' s medication regimen. This review shall occur within 30 days before or 30 days after the resident ' s admission, whenever there is a significant change in medication, and at least every 12 months. 2. At least annually, the CBRF shall have a physician, pharmacist, or registered nurse conduct an on-site review of the CBRF ' s medication administration and medication storage systems. 3. The CBRF shall obtain a written report of findings under subds. 1. and 2., and address any irregularities for appropriate action.	N 404		

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N 404	Continued From page 2 When the review is done by someone other than the prescribing practitioner, the prescribing practitioner shall receive a copy of the report when there are irregularities identified with the resident's medication regimen, which may need physician involvement to address. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that at least annually a physician, pharmacist, or registered nurse conducted an on-site review of the community based residential facility's (CBRF's) medication administration and medication storage systems. Findings include: The provider is licensed to care for 8 residents in the client groups advanced aged, developmentally disabled, and emotionally disturbed/mental illness. On 05/26/2026, Surveyor requested the Annual Medication Regimen Review for 2024 and 2025. Licensee C provided documents titled On-Site Medication Review dated 11/19/2024 and 12/01/2025. Surveyor observed both documents were signed by Manager D. At approximately 11:00 AM, Surveyor interviewed Licensee C who confirmed that Manager D was a certified nursing assistant (CNA). Licensee C confirmed they did have a registered nurse (RN) on staff, and s/he had delegated the Annual Medication Regimen Reviews to Manager D. The provider did not ensure a physician, pharmacist, or RN conducted on-site reviews.	N 404		

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N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a living environment that is safe, clean, comfortable, and homelike. Findings include: The provider is licensed to care for 8 residents in the client groups advanced aged, developmentally disabled, and emotionally disturbed/mental illness. On 05/26/2026 at approximately 10:30 AM, Surveyor toured the facility with Caregiver A. -Surveyor opened the lower-level exit door that leads to a stairwell and observed a cobweb covering approximately half of door entrance. Caregiver A stated, "I don't do bugs." Caregiver A guided Surveyor to the exterior of the building and showed Surveyor where the stairwell led. Caregiver A opened the door and Surveyor observed at least 25 live spiders and the entire stairwell was full of cobwebs. -Surveyor observed the stairs leading to the basement were poorly lit. At approximately 1:15 PM, Surveyor toured the	N 481		

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N 481	Continued From page 4 facility with Licensee C. -Surveyor inquired why the lighting was so poor in the stairwell. Licensee C stated s/he was aware the bulbs needed to be changed but they needed a special type of ladder and/or scaffolding to reach the fixture. Licensee C confirmed there had not been any falls, but the poor lighting was a hazard. -Surveyor observed that the railing on the front deck was very loose, and one of the deck boards was loose causing a lip that was a trip hazard. Licensee C stated they were considering removing the ramp as they were an ambulatory facility. -Licensee C confirmed that the exit that was full of spiders was a fire exit and they would ensure the stairwell was cleared of spiders and webs. The provider did not ensure the living environment was safe, clean, comfortable, and homelike.	N 481		
N 530	83.47(3) Fire inspection. Fire inspection. The CBRF shall arrange for an annual inspection by the local fire authority or certified fire inspector and shall retain fire inspection reports for 2 years. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an annual inspection by the local fire authority or certified fire inspector was completed.	N 530		

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N 530	Continued From page 5 Findings include: The provider is licensed to care for 8 residents in the client groups advanced aged, developmentally disabled, and emotionally disturbed/mental illness. On 05/26/2026, Surveyor requested the annual fire inspections. Licensee C provided documents titled Fire Extinguisher Inspections for 2024 and 2025 that included only information regarding 2 fire extinguishers. At approximately 12:00 PM, Surveyor interviewed Licensee C who stated s/he understood the fire department could no longer complete the fire inspections, and s/he must have misunderstood that the fire inspections could be completed by the same company that completed the fire extinguisher inspections. The provider did not ensure annual fire inspections were completed.	N 530		
N 671	83.61(1) Walls, ceilings subjected to moisture Walls and ceilings. Interior walls and ceilings in spaces subjected to moisture shall have water-resistant hard surfaces and no substantial surface irregularities or cracking. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure interior walls and ceilings in spaces subjected to moisture had water-resistant hard surfaces and no substantial surface irregularities or cracking.	N 671		

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N 671	Continued From page 6 Findings include: The provider is licensed to care for 8 residents in the client groups advanced aged, developmentally disabled, and emotionally disturbed/mental illness. On 05/26/2026 at approximately 1:00 PM, Surveyor toured the facility with Licensee C. In the lower-level bathroom, Surveyor observed the shower and shower area appeared to be under construction; -the full-size shower shell was approximately 4 to 6 inches from the ceiling, exposing wood framing; -approximately one quarter of the shower ceiling was uncovered and provided a view to pipes, framing, and the floor above; -on the right side of the shower was an area approximately 4-inches wide where there was no sheet rock (wall); -on the left side of the shower the wood frame to the shower was exposed; -a basement window was partially covered at the top, leaving approximately a 3 to 4 inch opening where someone could see into the shower from the outside. Licensee C stated the shower was functional but had been in this state for about a year. Licensee C stated they needed to have the ceiling completed, shower and walls sheet-rocked, and painted. Licensee C stated it had been challenging to find a contractor to complete the work. The provider did not ensure the interior walls and ceiling surrounding the shower were completed.	N 671		