

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0013426	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 05/13/2026
NAME OF PROVIDER OR SUPPLIER OUR HOUSE RICE LAKE MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 05/11/2026, Surveyor conducted a verification visit and complaint investigation at Our House Rice Lake Memory Care. Data was collected through 05/13/2026. One of 1 citation for Statement of Deficiency (SOD) T8KY12, dated 01/28/2026, was corrected. Three of 3 complaints were unsubstantiated. No new citations were identified. Under statutory provisions of Wis. Stat. ch. 50, a \$200 revisit fee is being assessed. Census: 17.	{N 000}		

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

TITLE

(X6) DATE