

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018856	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/14/2025
NAME OF PROVIDER OR SUPPLIER ALPHA ASSISTED LIVING AND MEMORY CARE HOWARD			STREET ADDRESS, CITY, STATE, ZIP CODE 2723 LINEVILLE ROAD HOWARD, WI 54313		
(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 05/08/2025, with information gathered through 05/14/2025, Surveyors conducted 6 complaint investigations at Alpha Assisted Living and Memory Care in Howard. Six (6) of 6 complaints were unsubstantiated. As a result of the survey, no deficiencies will be issued. Census: 40	N 000			

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

TITLE

(X6) DATE