STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018856	A. BUILDING: _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA ASSISTED LIVING AND MEMORY CARE HOW/	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 01/13/2025, with information gathered through 01/22/2025, Surveyors conducted 7 complaint investigations at Alpha Assisted Living and Memory Care in Howard. Two (2) of 7 complaints were substantiated. As a result of the survey, 2 deficiencies were issued. One (1) of 2 deficiencies is a repeat deficiency. See Statement of Deficiency (SOD) J0SO11 for additional details. Census: 40	N 000		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 (Resident 1 and 2) residents reviewed received all prescribed medications in the dosage and at intervals prescribed by a practitioner. Resident 1 was prescribed Erivedge (an oral chemotherapy drug) 150mg (milligrams) capsule take one capsule by mouth every day. Resident 1 did not receive this medication for 16 days from 12/18/2024 through 01/02/2025. Resident 2 was prescribed Ketoconazole 2% CR	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018856	A. BUILDING: _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA ASSISTED LIVING AND MEMORY CARE HOW/	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 352	Continued From page 1 (15) (PI) to apply topically once daily for seborrheic dermatitis and Culturelle Caps take one capsule by mouth 2 times a day with meals. Resident 2 did not receive these medications for 7 days from 12/09/2024 through 01/13/2025. This a repeat deficiency. See Statement of Deficiency (SOD) J0SO11 for additional details. Findings Include: On 12/23/2024, the department received a complaint regarding medications not administered per physician's orders. RESIDENT 1 On 01/13/2025, Surveyor conducted an onsite visit to the facility. A sample of residents was selected, including the record of Resident 1. Resident 1 admitted to the facility on 09/16/2021 with diagnoses to include diabetes mellitus due to underlying condition with hyperglycemia, adjustment disorder, hypertension and osteoarthritis of knee. Resident 1's ISP (Individual Service Plan) with a report date of 01/13/2025 stated Resident 1 is able to make own decisions. Resident 1 had an order for Erivedge 150mg (milligrams) capsule to take one capsule by mouth every day. Surveyor reviewed Resident 1's December and January 2024 MAR (Medication Administration Record). Resident 1 did not receive Erivedge from 12/18/2024 through 01/02/2025. The reason on the MAR for not receiving the medication is "has not been delivered," "not delivered," "unavailable from pharmacy at time of administration," "not here," or "don't have."	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018856	A. BUILDING: _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA ASSISTED LIVING AND MEMORY CARE HOW/	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 352	Continued From page 2 On 01/13/2025 at approximately 10:15AM, Surveyor interviewed LPN (Licensed Practical Nurse) B. LPN B stated Resident 1 was started on Erivedge about 1 1/2 months ago by his/her oncologist. LPN B indicated there was very little communication from the oncologist office about the medication. LPN B did acknowledge there was a "short gap" where Resident 1 did not get the medication, "about a week." LPN B stated it was a mixup with the pharmacy. LPN B stated in the past with other residents, the medications would automatically renew and the pharmacy would just send another cycle of medications. LPN B indicated with this medication because it was coming from a different pharmacy it did not automatically renew. The pharmacy wanted the facility to call the pharmacy a week or so before the prescription runs out to order the refill. LPN B stated s/he now knows to do this and has the date marked on his/her calendar to call the pharmacy to order the refill so Resident 1 does not go without it again. LPN B stated there was no negative affect to Resident 1. RESIDENT 2 On 01/13/2025, at 11:04AM, Surveyor interviewed Resident 2. Resident 2 informed Surveyor s/he has recently not been administered all of his/her medications. On 01/13/2025, at 5:45PM, Surveyor reviewed Resident 2's November - December 2024 and January 2025 medication administration record (MAR). Surveyor noted instances when medications were not passed. Corresponding reasons for medications not passed were indicated as medications not available or other problems with no other notations. The dates and	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018856	A. BUILDING: _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA ASSISTED LIVING AND MEMORY CARE HOW/	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 352	Continued From page 3 medications are as follows: Ketoconazole 2% CR (15) (PI) - Apply topically once daily for seborrheic dermatitis: (Order start date 12/09/2024) 12/25/2024 - not in cart 12/26/2024: other problems Culturelle Caps - Take one capsule by mouth 2 times a day with meals: (Order start date 01/08/2025) >AM Dose: 01/09/2025 - unavailable from pharmacy at time of pass 01/10/2025 - on order 01/11/2025 - on order 01/12/2025 - other problems 01/13/2025 - unavailable at the time of administration >PM Dose: 01/11/2025 - other problems 01/12/2024 - other problems On 01/22/2025, at approximately 1:55PM, Surveyor interviewed Director A. Director A acknowledged the finding and s/he will look into the issue to ensure the medications are ordered timely.	N 352		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the	Y3244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018856	A. BUILDING: _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA ASSISTED LIVING AND MEMORY CARE HOW/	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
Y3244	Continued From page 4 facility.	Y3244		

This Rule is not met as evidenced by:
Based on record review, observation and interview, the provider did not ensure residents received adequate and appropriate care within the capacity of the facility for Resident 2.

On 10/22/2024, the department received an allegation of inadequate care.

Findings Include:

On 01/13/2025, Surveyor reviewed Resident 2's hospital discharge summary dated 10/07/2024 to determine medical diagnosis. The discharge summary identified Resident 2 had state III chronic kidney disease, nephrostomy catheter tubes placed on the left kidney on 06/15/2024 and the right kidney on 08/15/2024. Additionally, the documentation noted Resident 2 has a history of anxiety, urinary retention, and bladder cancer. Resident 2 was seen in the emergency department for fever and concern for a urinary tract infection. Resident 2 was treated for a urinary tract infection with SIRS (systemic inflammatory response syndrome).

According to Cleveland Clinic, SIRS is defined as,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018856	A. BUILDING: _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA ASSISTED LIVING AND MEMORY CARE HOW/	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
Y3244	Continued From page 5	Y3244		

"SIRS (systemic inflammatory response syndrome) is a life-threatening medical emergency caused by your body's overwhelming response to a stressor. This could be things like an infection, trauma or a worsening health condition. SIRS requires prompt treatment in a hospital."

Information retrieved on 1/21/2025 at 9:42AM from:
https://my.clevelandclinic.org/health/diseases/25132-sirs-systemic-inflammatory-response-syndrome

Further review of the 10/07/2024 discharge revealed an order for home health services was ordered for Resident 2 for chronic disease management, home safety evaluation and falls prevention risk assessment. Additionally, the order specified monitoring for signs of decomposition/adverse events and medication management.

According to Cleveland Clinic, "A nephrostomy (pronounced "neff-ROSS-toh-mee") tube drains [urine] from your kidney. It's a tube your healthcare provider places to take [urine] directly from your kidney and channel it into a bag (nephrostomy bag). The bag has a valve on it so you can empty it. A surgeon or radiologist inserts the tube through the skin of your lower back into your kidney ..."

Cleveland Clinic identified possible complications of a nephrostomy as: "Bleeding. Infection. Injury to your kidney, bladder or ureters.
The nephrostomy tube falling out ..."

Cleveland Clinic noted tube inspections should be completed to check for: "Links or bends in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018856	A. BUILDING: _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA ASSISTED LIVING AND MEMORY CARE HOW/	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
Y3244	Continued From page 6	Y3244		

tubing. The tube won't drain into the bag if it's bent or kinked. Infection, swelling or redness where the tube meets your skin. Blood in the [urine] in your nephrostomy bag. Wet, dirty or loose dressings where the tube meets your skin. Your dressings should be clean and dry at all times.."

Information retrieved on 01/21/2025 at 10:12AM from https://my.clevelandclinic.org/health/treatments/25141-nephrostomy-tube

On 01/21/2025, at 10:30AM, surveyor reviewed the emergency department discharge documentation dated, 10/22/2024. The document noted Resident 2 was admitted to the hospital on 10/22/2024 through 10/29/2024 due to severe sepsis.

Emergency Department Overview 10/22/2024: " ...Pt (patient) here from Alpha Senior Concepts Assisted Living Facility via EMS s/p ground level fall after becoming lightheaded and dizzy ... Pt observed to be very ucnclean and appeared to not be well taken care of. Pt reports feeling like [s/he] does not receive the care [s/he] needs at the living facility. Social work consult placed. Pt's left neph (nephrostomy) tube appears to possibly be out of place as the stitches are about 2 inches from the skin and leakage no ted to be coming from the neph tube opening in the skin. Pt's chronic Foley catheter is not connected to a drainage bag and draining into the bed. Pt has a very strong malodorous body odor ... Pt was initially hypotensive here with systolic BP's in the 70's ... Pt has great excoriation to groin. Perineum ..."

ED Provider Diagnosis:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018856	A. BUILDING: _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA ASSISTED LIVING AND MEMORY CARE HOW/	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
Y3244	Continued From page 7	Y3244		

"Malfunction of nephrostomy tube, complicated urinary tract infection, acute kidney injury ..."

Emergency Department Course/Medical Decision Making:
" ...Upon arrival ... [s/he] is ill appearing and moderately disheveled with blanchable redness to the coccyx/sacrum/perineum as photographed above. [s/he] also arrives with [his/her] foley catheter not connected to a urinary drainage bag. [S/he] states that this frequently occurs while [s/he] is sleeping at night. RN (registered nurse) voiced concerns about the care the patient receives at [his/her] assisted living facility, social work was contacted as well. I discussed this with the patient who states that [s/he] is relatively independent and ambulatory at home and receives assistance with [his/her] medication and twice weekly baths. [S/he] states [s/he] has asked for help with [his/her] nephrostomy tubes but they have told [him/her] that they can't touch them ..."

"After reviewing the patient's initial triage data, the patient was found to have 2 or more SIRS criteria ... Clinical evaluation indicates likely source of infection is urinary ... I did explain to the patient that I believe inpatient admission would be best and safest plan ... Patient was in agreement with the disposition of the plan of inpatient admission ..."

Hospitalist Discharge Summary 10/29/2024:
"Indication for Admission: severe sepsis"

" ... pmh (past medical history) significant for chronic kidney disease ... chronic indwelling Foley catheter and bilateral nephrostomy tubes who presented to the St. Vincent's ED on 10/22 after a fall at [his/her] assisted living facility and increasing lethargy. [S/he] had signs of severe

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018856	A. BUILDING: _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA ASSISTED LIVING AND MEMORY CARE HOW/	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
Y3244	Continued From page 8	Y3244		

sepsis with tachycardia, leukocytosis, hypotension and elevated lactate and AKI .... Urine and nephrostomy tube cultures grew E. Coli, Proteus Mirabilis, Pseudomonas aeruginosa, Enterococcus faecalis resistant to vancomycin 10/25. ID was consulted and started on oral meropenem and IV linezolid through 11/06 ... A midline catheter was placed for continuation of IV antibiotics at the time of discharge ... The patient also presented with a sacral coccyx and scrotum rash which was evaluated and treated by wound care."

"Disposition: SNF (skilled nursing facility) for IV antibiotics."

On 01/13/2024 at 10:08AM, Surveyor interviewed Licensed Professional Nurse - B (LPN-B). LPN-B specified home health was obtained for Resident 2 to manager flush the nephrostomy tubes. Currently, Resident 2 is on hospice, and they now provide the management and flushes. LPN-B reported Resident 2 no longer uses a foley catheter. LPN-B specified Resident 2 emptied and replaced the catheter bag. There were issues when Resident 2 experienced falls. There were times the catheter bag came off with the fall and an occasion where the tubing was ripped off/out. LPN-B identified Resident 2 has had 3 falls with his/her walker since returning from skilled nursing. LPN-B was interviewed about Resident 2's severe rash in the peri area that was discovered in the emergency department. LPN-B could not recall if any wounds were identified by the provider prior to going to the emergency department on 10/22/2024. LPN-B reported Resident 2 has a diagnosis of psoriasis. LPN-B explained it is an autoimmune issue that can flare up. It presents with dry patches of raised skin. They can be red in color and become infected if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018856	A. BUILDING: _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA ASSISTED LIVING AND MEMORY CARE HOW/	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
Y3244	Continued From page 9	Y3244		

not treated. LPN-B stated if it becomes infected there "is not a ton" they can do." LPN-B added antibiotics can be prescribed along with additional bathing.

On 01/13/2025, at 11:04AM, Surveyor observed and interviewed Resident 2. Surveyor observed Resident 2's right and left nephrostomy tubes, with bag that was kept in his/her jacket pockets. Resident 2 recalled being hospitalized in October 2024. Resident 2 reported s/he attempted to get up but felt weak and fell. Resident 2 confirmed the nephrotomy tube was ripped out during the fall. Resident 2 confirmed s/he no longer has a foley catheter but did empty the bag independently. Resident 2 could not recall why the catheter bag the day s/he went to the emergency department. Resident 2 stated s/he has psoriasis and has lotion that is applied to the active areas. Resident 2 advised s/he takes twice weekly showers. Caregivers assist with washing his/her back so the nephrostomy tubes do not get pulled out. Resident 2 stated the hospice provider currently provides nephrostomy care. Resident 2 reiterated the staff at the assisted living will not touch the nephrostomy. Resident 2 confirmed s/he has psoriasis and showed surveyor his/her leg with visible raised dry patches.

On 01/13/2025, at approximately 11:20AM, Surveyor interviewed Caregiver C regarding what kind of cares are provided for Resident 2. Caregiver C reported s/he knows Resident 2 has psoriasis and nephrostomy tubes. Caregiver C advised s/he does not know anything about the tubes as hospice provides all the care necessary. Caregiver C stated Resident 2 needs minimum assistance and is very independent with cares.

On 01/13/2025 at approximately 5:10PM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018856	A. BUILDING: _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA ASSISTED LIVING AND MEMORY CARE HOW/	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
Y3244	Continued From page 10 Surveyor reviewed Resident 2's individual support plan (ISP) dated 11/25/2024. The ISP noted Resident 2 was admitted on 09/19/2024. Surveyor identified the ISP did not include any information on diagnosis identified by the 10/03/2024 emergency department discharge or the 10/22/2024 - 10/29/2024 hospital discharge. Surveyor noted the ISP did not have any information in multiple applicable sections. The sections were as follows: Nursing Procedures: No information regarding Resident 2's nephrostomy tubes or coordination with hospice's management of the tubes. The ISP did not indicate what caregivers should know or what should be communicated with hospice regarding the tubes. Long-Term Illness: No information documenting Resident 2's diagnosis stage III kidney disease or history of bladder cancer. Re-Occurring Illness: (1) No information regarding the diagnosis of psoriasis as confirmed by LPN-B and Resident 2's interviews. There was no information regarding monitoring Resident 2's skin for psoriasis flare ups. (2) There was no information on re-occurring UTI's due to the nephrostomy tube placement. Instability Management: No information regarding the uses of a walker or increase in falls since returning from skilled nursing as stated in the interview with LPN-B. Additionally, the ISP stated the following regarding bathing: "Resident is unable to complete induvial task without complete physical assistance ...As needed every other day ... Staff responsible for fulling assisting resident with all	Y3244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018856	A. BUILDING: _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA ASSISTED LIVING AND MEMORY CARE HOW/	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
Y3244	Continued From page 11 bathing tendencies." On 1/22/2025, at approximately 1:50PM, Surveyor interviewed Director A. Director A acknowledged the ISP did not include all needed information. Director A advised the ISP was updated on 01/15/2025 for change in condition. Resident 2's ISP did not include all necessary information needed to provide appropriate care. On 10/07/2024 Resident 2 went to the emergency department and was treated for a urinary tract infection with systemic inflammatory response syndrome. On 10/22/2024, Resident 2 was taken to the emergency department due to a fall. During the emergency department assessment, it was determined Resident 2 arrived with a strong body odor, no catheter bag for collection of urine, a dislodged nephrostomy tube, wounds to the peri-area requiring wound care and severe sepsis. Prior to returning to the assisted living facility, Resident 2 was discharged from the hospital to a skilled nursing facility to receive IV antibiotics to treat the severe sepsis.	Y3244		