STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	390124	A. BUILDING: _____ B. WING _____	C 04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA HOMES OF WISCONSIN VIII	101 11TH AVE RACINE, WI 53403

(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
M 000	INITIAL COMMENTS On 04/15/2025, Surveyor completed a self-report review. One violation was identified as a result of the self-report review. Census: 3	M 000		
M 436	88.07(2)(a) SERVICES The licensee shall provide or arrange for the provision of individualized services specified in a resident's individual service plan that are the licensee's responsibility. This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure services specified in 1 of 1 resident's individual service plan (ISP) was followed. Resident 1's plan required continuous line of sight supervision and dietary modifications, including thickened liquids due to an identified choking risk. Resident 1 was left unattended and accessed a bowl of food and water at the kitchen sink. Resident 1 consumed the food and water; this resulted in a choking event that led to Resident 1's death. Findings include: On 02/24/2026, The Department received a self-report indicating a choking incident which resulted in the death of a resident. The self-report, dated 02/19/2026, reported Resident 1 died after experiencing a choking incident. The self-report indicated Resident 1 was on the couch	M 436		

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

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M 436	Continued From page 1	M 436		

after s/he ate a meal, and Caregiver C placed uneaten food from the meal (chicken, rice, and fries) in the sink and added water prior to putting down the garbage disposal. Caregiver C needed to use the restroom and was gone approximately 1 minute. When Caregiver C came out of the bathroom s/he observed Resident 1 standing by the sink and s/he seemed to be having trouble breathing. It appeared to Caregiver C that Resident 1 had possibly ingested some of the leftover food from the sink. Caregiver C called 911 and began CPR immediately until emergency medical technicians (EMTs) arrived and took over. They were unable to clear Resident 1's airway and Resident 1 was pronounced deceased at the scene.

On 04/14/2026, at approximately 11:40 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 09/21/2015 with diagnoses of dysphagia, diverticulitis, seizure disorder, autism, manic depressive disorder, mental retardation, and bipolar disorder. Resident 1 had a guardian.

Resident 1's ISP dated 02/24/2026, stated the following: "1. staff must grind all food/meat and add sauce or gravy. Watch for pocketing of food on/in sides of his/her cheeks. S/he must be sitting at a full 90 degree angle during and after all meals for 30 minutes. 2. Thick it to all liquids honey consistency. 3. No food in his/her reach that is not mechanically soft. 4. History of seizures. 5. Self -abusing behavior. 5.[sic] Wandering risk- door alarms. 6. Line of sight consumer."

Under the supervision section, the ISP stated," S/he requires 24 hour services. S/he does not have any safety skills and must always be

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M 436	Continued From page 2 monitored for meals and snacks." On 04/14/2026, at approximately 12:00 PM, Survey interviewed Senior Coordinator A and Human Resources Director (HR) B. Senior Coordinator A reported on 02/19/2026, Caregiver C placed Resident 1's food bowl from lunch in the kitchen sink and ran water into the bowl and walked away to use the bathroom. Resident 1 was reported to be in the common area when Caregiver C walked away to use the bathroom. Caregiver C was reported to return to the kitchen and observed Resident 1 standing bent over near the sink in the kitchen unable to breathe properly. Senior Coordinator A reported Resident 1 drunk the liquid from the bowl placed in the sink and choked. Senior Coordinator A reported s/he was notified by Caregiver C of the incident and 911 was called, while Caregiver C started abdominal thrust with the instructions of a 911 operator. Senior Coordinator A arrived at the facility when emergency services were doing compressions on Resident 1. Senior Coordinator A reported, Caregiver C, emergency services, and the Racine County Police Officers attempted to clear Resident 1's throat and was unable to dislodge the food trapped in Resident 1's throat. Senior Coordinator A reported Resident 1 was not known to go to the kitchen sink and indicated Resident 1 normally tried to take food items that were within plain sight and reach. Senior Coordinator A acknowledged Resident 1 was a choking risk and required line of sight supervision during all meals. HR Director B reported s/he arrived at the facility when emergency services worked on Resident 1 to dislodge the food in his/her throat. HR Director B reported Resident 1 was known to walk away from his/her food while eating and return to eat more, however Resident 1 was not known to	M 436		

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M 436	Continued From page 3 retrieve food or water from the kitchen sink. HR Director B reported Caregiver C was trained/certified in cardiopulmonary resuscitation (CPR), first aid, and choking training in 2025. HR Director B reported all staff were given additional trainings surrounding ISP review, choking/ first aid, CPR review, and safe eating training after this incident.	M 436		