

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017124	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/11/2026
NAME OF PROVIDER OR SUPPLIER ATTIC ANGEL PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 8301 OLD SAUK RD MIDDLETON, WI 53562		
(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 08/11/2026, Surveyor conducted a complaint investigation at Attic Angel Place, a CBRF located in Middleton, WI. As a result of the investigation, 2 violations of Chapter DHS 83 were issued. The complaint was substantiated.	N 000		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties.	N 239		

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

TITLE

(X6) DATE

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N 239	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Caregiver B was trained in first aid and choking. Caregiver B had first aid and choking training completed by the American Red Cross dated 12/28/2010. Findings include: On 08/11/2026 at 10:20 AM, Surveyor reviewed Caregiver B's employee file to confirm compliance. Caregiver D was hired 12/14/2014. There was no documented completion of training or exemption from training in first aid and choking. Caregiver D had a certificate of completion in first aid and choking training from the American Red Cross dated 12/28/2010, which was 8 months after the deadline of 04/01/2010 according to DHS 83 regulations. Administrator A stated that s/he did not know of the deadline and assumed the training would be grandfathered in. On 08/11/2026 at 11:15 AM Surveyor checked the Wisconsin Community Based Care and Treatment Registry and confirmed that Caregiver D was not on the registry for first aid and choking. On 08/11/2026 at 12:00 PM, Surveyor interviewed Administrator A. Administrator A acknowledged that all caregivers must complete training in first aid and choking within the first 90 days of employment. Administrator A stated that s/he did not know of the deadline of the caregiver registry. Administrator A stated that all employees ongoing will be trained in first aid and choking within the first 90 days of employment.	N 239		

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N 348	Continued From page 2	N 348		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Resident 1 was free from mistreatment. Resident 1 was found with marks and bruising to his/her face consistent with being struck. Findings include: On 08/07/2026, the Department received a complaint alleging that a resident was possibly abused by a caregiver. On 08/11/2026 at 10:00 AM, Surveyor reviewed Resident 1's medical record. Resident 1 was admitted 05/27/2025 with diagnoses that include but are not limited to: Alzheimer's disease, Diabetes Type II, HTN, hyperlipidemia, anemia, heart failure, kidney failure, heart failure unspecified, macular degeneration, paroxysmal atrial fibrillation, occlusion and stenosis of bilateral carotid arteries, GERD, anxiety, chronic kidney disease stage 3. On 08/11/2026 at 10:30 AM, Surveyor reviewed facility documentation dated 08/2/2026.	N 348		

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N 348	Continued From page 3 Administrator A was called from Nurse B on 08/01/2026 at 10:14 AM to report a large bruise to Resident 1's right cheek. Power of Attorney C (POA-C) notified. Caregiver D had reported the injury to Lead E and did not provide further cares for Resident 1. It was documented that after reporting Resident 1's injury, Caregiver D did not assist Resident 1 with cares after s/he reported. When Caregiver D was asked why s/he did not assist Resident 1 with cares after s/he reported the injuries, Caregiver D stated that s/he was scared and did not go into Resident 1's room. Caregiver D was asked if s/he was the first to see Resident 1's injuries. Caregiver D stated that s/he may have been, but the PM shift may have forgotten to report the injuries. Administrator A provided a picture of Resident 1's injuries dated 08/04/2026 at 1:15 PM. The picture shows extensive bruising to Resident 1's right cheek with what appear to be 3 distinct marks that were made by fingers. The picture would indicate that Resident 1 was struck by a hand. (See photo) On 08/02/2026 at 10:54 AM Caregiver H gave a written statement. Caregiver H stated s/he saw Resident 1 around noon on 08/01/2026, Resident 1 had no marks or bruising on his/her face at that time. Caregiver H stated that on 08/02/2026 at 6:30 AM, Caregiver G asked Caregiver H to look at Resident 1. Caregiver H stated there was now bruising to Resident 1's right cheek, dark reddish and right ear was bright red and hot to touch. On 08/02/2026 at 12:21 PM, Caregiver C gave a written statement. Caregiver C stated s/he left around 2:30 PM on 08/01/2026 at end of AM shift. Caregiver C stated s/he did see Resident 1 as s/he was calling for help around that time.	N 348		

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N 348	Continued From page 4 Caregiver C stated s/he stopped in to see what Resident 1 wanted, and was told Resident 1 didn't need help. Caregiver C stated s/he did not see any marks or discoloration on Resident 1's face. On 08/03/2026 at 9:54 AM, Caregiver I gave a written statement. Caregiver I stated s/he was the medication passer on the PM shift 08/01/2026. Caregiver I stated that s/he did not see any marks on Resident 1's face during the PM shift as Caregiver I had seen Resident 1 a few times to pass medications and check on him/her during the PM shift. On 08/03/2026 at 10:13 AM, Caregiver F was interviewed by Administrator A. Caregiver F stated s/he worked the PM shift on 08/01/2026. Caregiver F stated s/he did not work with Resident 1 due to Resident 1 preference. Caregiver F stated that s/he delivered Resident 1's meal tray but did not assist with any direct cares. Caregiver F stated that there was no report that Resident 1 fell during the PM shift 08/01/2026. Caregiver F reported that s/he did not see any bruising or anything unusual about Resident 1's appearance during the PM shift on 08/01/2026. On 08/04/2026 at 9:18 AM, Caregiver G was interviewed by Administrator A. Caregiver G stated that s/he assisted Resident 1 with cares on the PM shift on 08/01/2026. Caregiver G stated that during bedtime (hs) cares, Resident 1 was resistive to cares and transfer from recliner to his/her bed using the EZ Lift. Caregiver G stated that Resident 1 did not hit his/her head on the EZ Lift during transfer. Caregiver G stated that once Resident 1 was in bed, s/he fell asleep on left side and right cheek facing out. Caregiver G	N 348			

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N 348	Continued From page 5 stated there were no marks on Resident 1's face during the PM shift 08/01/2026. On 08/04/2026 at 1:33 PM, Lead E was interviewed by Administrator A. Lead E stated s/he worked the NOC shift 08/01/2026 into 08/02/2026. Lead E stated that Caregiver D had reported to him/her during the NOC shift. that there was a bruise on Resident 1's face and appeared new. Lead E stated that "something seemed off. You could tell the bruise was fresh, and his/her ear was bright red like it had just been hit." Lead E stated that s/he asked Caregiver D what happened and Caregiver D responded s/he didn't know, but it must have happened on the PM shift." Lead E stated s/he noticed that since Caregiver D had reported the injury to him/her, that Caregiver D was acting abnormal. Caregiver D would not make eye contact and wouldn't speak to Lead E. Caregiver G described this as odd as s/he and Caregiver D had worked together for 10 years. Lead E stated that could not have gotten the bruise from "sleeping on it wrong" because for all the time Caregiver G has been working with Resident 1, s/he will not sleep on his/her right side and will yell until s/he is positioned on his/her left side. On 08/11/2026 at 11:30 AM, Surveyor interviewed Administrator A. Administrator A stated that the injury was suspicious and looked intentional. Administrator A stated s/he doubted that the bruise to Resident 1's right cheek was the result of being struck by the EZ Lift as the bars were well padded. Administrator A stated that the bruise was large and there appeared to be 3 finger marks across Resident 1's right cheek. Administrator A stated, "I am an RN and I have extensive training in identifying these types of injuries. We narrowed down the timeline to the	N 348			

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N 348	Continued From page 6 NOC shift on 08/01/2026 into 08/02/2026 and Caregiver D was the only caregiver to come in contact with Resident 1 as s/he does not get medication on the NOC shift. We interviewed Caregiver E and F, who worked the PM shift on 08/01/2026, they worked together to assist Resident 1 with cares so they witnessed everything the other did. Neither Caregiver E or F reported anything unusual about Resident 1. Caregiver D was the one that reported the injury and blamed Caregivers E and F. Caregiver G saw the injury and thought it was suspicious and reported it immediately to me. Caregiver H had an interaction the next shift with Caregiver D, and it was out of line with Caregiver D's normal demeanor. Caregiver D did not perform cares with Resident 1 after s/he reported to Caregiver G. Caregiver D was verbally aggressive to Caregiver H when talking about Resident 1, and why Caregiver D did not get Resident 1 up for the day, which is normal procedure. We have concluded that Caregiver D is responsible for the injury to Resident 1's right cheek. Caregiver D has been suspended until the investigation is concluded."	N 348		