Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017309	A. BUILDING: _____ B. WING _____	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS TOUCH ASSISTED LIVING	394 ANGELS TOUCH CT DE PERE, WI 54115

(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 09/17/2024, Surveyor conducted 3 complaint investigations at Angels Touch Assisted Living (2.) Additional information was gathered through 10/01/2024. All 3 complaints were unsubstantiated. One deficient practice was identified. Census: 19	N 000		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure the CBRF complied with all laws governing the CBRF. The provider was aware of allegations Resident 1 was conducting illegal activities on his/her computer via the provider's internet service on campus and did not immediately alert the authorities. Findings include: On 09/17/2024, Surveyor reviewed Resident 1's file as a part of a complaint investigation at the facility. Surveyor noted no incident report was present in Resident 1's record nor was a self-report submitted to the Department regarding allegations of illegal activity. On 09/17/2024 at approximately 2:30 PM, Surveyor interviewed Administrator A and Manager B. Manager B stated s/he believed Surveyor must be investigating concerns related to Resident 1 due to the caregivers' recent	N 196		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017309	A. BUILDING: _____ B. WING _____	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS TOUCH ASSISTED LIVING	394 ANGELS TOUCH CT DE PERE, WI 54115

(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 196	Continued From page 1 allegations against Resident 1. Surveyor requested additional information. Manager B stated within the last 7-10 days it had been brought to his/her and Administrator A's attention by multiple caregivers (unnamed) that Resident 1 was conducting illegal activity online, noticed by caregivers in passing and while doing cares in Resident 1's room. Manager B described what caregivers reported witnessing and stated, if it were true, s/he was aware it was illegal activity. Administrator A and Manager B both denied calling the police or local authorities to investigate the allegations and denied conducting an internal investigation. Administrator A and Manager B stated they did not call the police as they did not know if they had enough proof to call based on caregiver allegations. Administrator A and Manager B reviewed the code and acknowledged their responsibility to comply with the law by reporting allegations of criminal activity to the proper authorities and to allow the authorities to conduct an investigation. On 09/18/2024, Surveyor interviewed Administrator A at 10:29 AM. Administrator A stated s/he called the police after Surveyor left on 09/17/2024. Administrator A stated based on the allegations reported to the police, 3 police arrived and confiscated Resident 1's computer for investigation without incident.	N 196		