STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014805	A. BUILDING: _____ B. WING _____	C 11/06/2025

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CHARTER SENIOR LIVING CBRF-VERONA	143 PRAIRIE OAKS DRIVE VERONA, WI 53593

(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 From 11/03/2025 to 11/06/2025, Surveyors conducted a complaint investigation and standard survey at Charter Senior Living CBRF, a CBRF in Verona. Eight deficiencies were identified. Four deficiencies were repeat deficiencies - See Statement of Deficiency (SOD) 5UV911, dated 04/04/2022, SOD 5UV912, dated 09/14/2022 and SOD UDCH11, dated 08/02/2024. The complaint was substantiated. Census: 17	N 000		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: Resident rights. Training shall include general rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after starting employment. Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as	N 243		

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

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N 243	Continued From page 1 applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting employment. Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group. Recognizing, preventing, managing, and responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment. This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure 2 of 3 employees reviewed obtained all training as required within 90 days after starting employment. Caregiver C did not have training in resident rights within 90 days after starting employment. Caregiver C and Caregiver D did not have training in recognizing, preventing, managing and responding to challenging behaviors within 90 days after starting employment.	N 243		

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N 243	Continued From page 2 This is a repeat deficiency. See Statement of Deficiency (SOD) UDCH11, dated 08/02/2024. Findings include: On 11/03/2025 at approximately 12:40 p.m., Surveyor conducted a review of 3 employees to verify compliance with all employee training requirements. Surveyor requested training records from Executive Director A for Caregiver C and Caregiver D. Resident Rights The record for Caregiver C, hired 07/22/2025, did not contain evidence of training or evidence of meeting an exemption for resident rights. On 11/03/2025, at approximately 3:00 p.m., Surveyor interviewed Executive Director A and Regional Director B. Executive Director A confirmed the provider did not have evidence Caregiver C completed or met an exemption for resident rights training at the moment, but that s/he would review the employee records again. Recognizing, Preventing, Managing and Responding to Challenging Behaviors The record for Caregiver C, hired 07/22/2025 and Caregiver D, hired 07/22/2025, did not contain evidence of training or evidence of meeting an exemption for challenging behaviors training. On 11/03/2025, at approximately 3:00 p.m., Surveyor interviewed Executive Director A and Regional Director B. Executive Director A stated s/he would review employee records again to see if there was a training course that covered challenging	N 243		

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N 243	Continued From page 3 behaviors. Executive Director A was given the opportunity to submit any additional evidence of training through 11/04/2025. Training documentation was not received.	N 243		
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 1 of 4 residents reviewed received all medications as prescribed. Resident 4 did not receive his/her Oxycodone 5 mg as prescribed. Findings include: On 11/05/2025 at 8:00 a.m., Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider's facility on 10/29/2025 with diagnoses including behavioral and psychological symptoms of dementia. Resident 4's physician orders included Oxycodone 5 mg tab (Start Date: 10/29/2025) - Take ½ tablet (2.5 mg) by mouth every 6 hours as needed for acute pain.	N 352		

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N 352	Continued From page 4 On 11/03/2025 at 11:25 a.m., Surveyor reviewed the facility's medication cart with Caregiver E. Surveyor noted Resident 4's oxycodone was in a pill bottle in the narcotic drawer. Caregiver E indicated Health & Wellness Director G would place the oxycodone in a bubble pack soon, as Resident 4 was recently admitted to the facility. Caregiver E indicated the oxycodone must be cut in half to administer the correct dose to Resident 4 as indicated in the order. Surveyor reviewed the facility's Individual Resident Controlled Substance Record for Resident 4's oxycodone 0.5 mg tab, dated 10/29/2025 to 11/03/2025. Surveyor noted Caregiver E had given Resident 4 1 oxycodone 5 mg tablet on 11/01/2025 at 1:08 p.m. instead of 0.5 tablets. Surveyor asked Caregiver E about this. Caregiver E indicated Resident 4 had requested a whole tablet instead of a half tablet that day. Surveyor asked Caregiver E if this would be considered a medication error. Caregiver E said yes. On 11/05/2025 at 8:00 a.m., Surveyor reviewed Resident 4's medication administration record (MAR), dated 11/01/2024 through 11/04/2025 and compared it to Resident 4's Individual Resident Controlled Substance Record. The MAR documented the following discrepancies with the Oxycodone 5 mg administration: -11/01/2025 at 1:08 p.m.: MAR documentation - Dose: 0.5 tabs / Controlled Substance Record documentation - 1 tab given -11/02/2025 at 2:00 p.m.: No MAR documentation / Controlled Substance Record documentation - 0.5 tabs given. -11/03/2025 at 4:32 p.m.: MAR documentation - Dose: 0.5 tabs given	N 352		

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N 352	Continued From page 5 -11/03/2025 at 5:00 p.m.: MAR documentation - Dose: 0.5 tabs given *Surveyor noted administration was not 6 hours apart as indicated in order. On 11/03/2025 at approximately 3:00 p.m., Surveyor shared concerns about Resident 4's oxycodone administration with Executive Director A and Regional Director B. Regional Director B agreed administering 1 tab when the order was for 0.5 tabs was a medication error and Executive Director A made note of Surveyor's concern.	N 352		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 residents reviewed had their needs, abilities, and physical and mental condition assessed when there was a change in needs, abilities or condition.	N 381		

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N 381	Continued From page 6 Resident 1 and Resident 2 did not have updated fall assessments after sustaining falls. Findings include: On 11/03/2025 at approximately 1:00 p.m., Surveyor reviewed resident records and identified the following concerns: Example 1 - Resident 1: Resident 1 was admitted to the provider's facility on 08/01/2025. Resident 1's individual service plan (ISP), dated 08/01/2025, documented that s/he was a fall risk with the following interventions listed: - Observe for changes in gait, balance, cognition or medication that may increase fall risk. - Encourage use of call pendant and remind to wait for assistance when needed. - Refer to therapy for strength and balance training. - Assist to keep living space clutter-free with adequate lighting. - Use grab bars in the bathroom. - Provide supervision during high-risk activities. - Encourage participation in exercise program. Surveyor noted Resident 1's record did not include a fall assessment completed since admission and the ISP had not been updated with interventions to prevent falls since 08/01/2025, Resident 1's date of admission. Resident 1's record, dated 08/01/2025 to 11/03/2025, included reports of the following incidents: - 08/31/2025 3:59 p.m.: Resident pressed his/her	N 381		

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call pendant around 3:10 p.m. Resident was on the edge of his/her bed with his/her back against the bed. Resident claimed s/he had slipped of the bed because s/he was sitting there improperly. Resident was assisted off the floor.
- 08/31/2025 7:57 p.m.: Resident activated his/her pendant around 5:35 p.m. Resident was in the bathroom, between the toilet and wall, sitting in an upright position on his/her bottom. Resident was sitting in his/her feces and urine.
- 09/09/2025 9:21 p.m.: Resident went to the bathroom and when s/he was done, s/he tried to transfer him/herself from the toilet to his/her chair. Resident used his/her call pendant. When staff entered room, resident was found on his/her bathroom floor.
- 09/23/2025 8:27 p.m.: Resident was found on his/her right side, back facing his/her bed. Resident stated s/he was trying to go to the bathroom and rang when s/he was on the floor.
- 09/26/2025 1:00 a.m.: Went to answer call and found him/her on the bathroom floor.
- 10/03/2025 10:00 a.m.: Resident was found laying on the bathroom floor between the sit-to-stand machine and the toilet. When asked why s/he didn't ring for assistance, s/he stated s/he didn't want to wait.
- 10/15/2025 11:40 a.m.: Resident tried to transfer him/herself from his/her wheelchair to the bathroom again and fell on his/her back.
- 10/19/2025 6:30 a.m.: Resident was calling for help and found on floor in the entry way of his/her bathroom on his/her back. S/he was trying to transfer to bathroom and didn't want to use the wheelchair because "it takes too long." Incontinent of urine.
- 10/29/2025 2:53 a.m.: Pendant went off at approximately 1:57 a.m. and resident was found

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on the floor, sitting on his/her rear-end, with his/her head leaning against the middle part of his/her bed.

Example 2 - Resident 2:

Resident 2 was admitted to the provider's facility on 10/24/2025. Resident 2's ISP, dated 10/23/2025, documented that s/he was a all risk and stated to observe for changes in gait, balance, cognition, or medications that may increase fall risk. Surveyor noted Resident 2's record did not include a fall assessment completed since admission and the ISP had not been updated with interventions to prevent falls since 10/23/2025. Resident 2's record, dated 10/24/2025 to 11/03/2025, included reports of the following incidents:

- 10/30/2025 1:45 p.m.: Caregivers found resident on the floor in his/her room outside the bathroom. Resident's pants were down, foley out with balloon intact and blood covering the floor.
- 10/30/2025 5:00 p.m.: Resident was found on the floor in a prone position trying to get off the floor by him/herself. *Staff was instructed resident would be assist of 2 and to push Lorazepam if resident gets too anxious.
- 10/31/2025 2:45 p.m.: Resident was found on floor this morning. Resident was too restless to get proper vitals.

On 11/03/2025 at approximately 2:30 p.m., Surveyor reviewed concern with Executive Director A that residents who had sustained falls had not had updated fall assessments. Executive Director A stated s/he would review the records and provide Surveyor with a fall assessment if s/he located

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N 381	Continued From page 9 one. Executive Director was given through 11/04/2025 to provide follow up documentation. Documentation of assessments was not received.	N 381		
N 393	83.35(5)(a) Initial evaluation of evacuation limitations. Initial evaluation. The CBRF shall evaluate each resident within 3 days of the resident ' s admission to determine whether the resident is able to evacuate the CBRF within 2 minutes in an unsprinklered CBRF and 4 minutes in a sprinklered CBRF without any help or verbal or physical prompting, and what type of limitations that resident may have that prevent the resident from evacuating the CBRF within the applicable period of time. A form provided by the department shall be used for the evaluation. The resident ' s evaluation shall be retained in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 residents were evaluated for evacuation capabilities within 3 days of the resident's admission. Resident 3 did not have an evacuation assessment completed upon admission. This is a repeat deficiency. See Statement of Deficiency (SOD) 5UV911, dated 04/04/2022 and SOD 5UV912, dated 09/14/2022. Findings include:	N 393		

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N 393	Continued From page 10 On 11/03/2025 at approximately 11:00 a.m., Surveyor requested to review Resident 3's records. Resident 3 had an admission date of 01/14/2025. Resident 3's file contained a Resident Evacuation Assessment, DQA Form F-62373 that was completed and dated 12/07/2024. On 11/03/2025 at 11:10 a.m., Surveyor interviewed Executive Director A regarding the date discrepancy on the evacuation assessment form. Executive Director A indicated Resident 3 had moved to the memory care unit on 01/14/2025 from the assisted living facility and did not believe a new evacuation form had been completed. On 11/03/2025 at approximately 3:00 p.m., Surveyor shared findings with Executive Director A, Regional Director B, and Health & Wellness Director G. Health & Wellness Director G indicated an updated evacuation assessment had been completed for Resident 3 but was unable to locate it. Executive Director A indicated the Resident Evaluation Assessment, DQA Form F-62373 had not been completed again after Resident 3 moved into the facility.	N 393		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication	N 415		

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administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 2 of 3 residents reviewed had their response to PRN medications documented.

Resident 2's response to Lorazepam, Haloperidol and Hydromorphone was not documented for 6 administrations from 10/24/2025 to 11/06/2025.

Resident 4's response to Oxycodone was not documented for 3 administrations from 10/29/2025 to 11/06/2025.

This is a repeat deficiency. See Statement of Deficiency (SOD) 5UV912, dated 09/14/2022.

Findings include:

RECORD REVIEW

On 11/03/2025 at approximately 1:00 p.m., Surveyor reviewed resident records, which documented the following concerns:

Example 1 - Resident 2:

Resident 2 was admitted to the provider's facility on 10/24/2025. Resident 2's record indicated the provider's staff administered his/her medications. Resident 2's medication administration record

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N 415	Continued From page 12 (MAR), dated 10/24/2025 to 11/06/2025 documented the following: - 10/30/2025 9:34 p.m. Lorazepam administered for anxiety/restlessness. *No response/outcome documented. - 10/31/2025 1:23 a.m. Lorazepam administered for restless. *No response/outcome documented. - 10/31/2025 7:21 a.m. Lorazepam administered for anxiety. *No response/outcome documented. - 10/31/2025 11:37 a.m. Lorazepam administered for anxiety. *No response/outcome documented. - 10/31/2025 11:37 a.m. Haloperidol administered for anxiety. *No response/outcome documented. - 11/04/2025 11:02 a.m. Hydromorphone administered per hospice. *No response/outcome documented. Example 2 - Resident 4: Resident 4 was admitted to the provider's facility on 10/29/2025. Resident 4's record indicated the provider's staff administered his/her medication. Resident 4's physician orders included an order, dated 10/29/2025, for Oxycodone 5 mg - Take ½ tablet (2.5 mg) every 6 hours as needed for acute pain. Resident 4's MAR, dated 10/29/2025 to 11/06/2025, documented the following: - 11/01/2025 at 1:08 p.m.: Oxycodone administered for back pain. *No response/outcome documented. - 11/03/2025 4:32 p.m.: Oxycodone administered for back pain.	N 415		

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N 415	Continued From page 13 *No response/outcome documented. - 11/03/2025 5:00 p.m. Oxycodone administered for back pain. *No response/outcome documented. INTERVIEW On 11/06/2025 at approximately 8:40 a.m., Surveyor interviewed Executive Director A. Executive Director A stated s/he believed the responses to PRN medications should be documented in the MAR, but that s/he would check records and provide Surveyor with any follow up information. On 11/06/2025 at approximately 2:00 p.m., Executive Director A provided Surveyor with follow up documentation, which did not include responses to PRN medications.	N 415		
N 425	83.38(1)(a) Personal care. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Personal care. Personal care services shall be designed and provided to allow a resident to increase or maintain independence.	N 425		

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	0014805	A. BUILDING: _____ B. WING _____	C 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SENIOR LIVING CBRF-VERONA	143 PRAIRIE OAKS DRIVE VERONA, WI 53593

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N 425	Continued From page 14	N 425		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure personal care services were provided to meet the needs of residents. Resident 1's request for assistance via call light was not responded to for greater than 30 minutes 32 times from 10/01/2025 to 11/03/2025.

This is a repeat deficiency. See Statement of Deficiency (SOD) 5UV911, dated 04/04/2022.

Findings include:

From 11/03/2025 to 11/04/2025, Surveyors conducted a complaint investigation alleging resident call lights when unanswered for long periods of time.

On 11/03/2025 at approximately 1:00 p.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 08/01/2025. Resident 1's individual service plan (ISP), dated 08/01/2025, indicated s/he required assistance with personal hygiene needs, including incontinence care, required a sit-to-stand for transfers and used a wheelchair for mobility. Resident 1's record included an incident report, dated 10/03/2025, stating Resident 1 fell in the bathroom and when asked why s/he didn't call for help, Resident 1 stated s/he didn't want to wait. Resident 1's call light log, dated 10/01/2025 to 11/03/2025, documented the following call light response times greater than 30 minutes:

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N 425	Continued From page 15 - 10/04/2025 8:08 a.m. - 49 minutes *4 minutes to acknowledge - 10/04/2025 11:43 a.m. - 89 minutes *5 minutes to acknowledge - 10/06/2025 12:29 p.m. - 52 minutes *8 minutes to acknowledge - 10/06/2025 3:27 p.m. - 99 minutes *24 minutes to acknowledge - 10/07/2025 5:44 p.m. - 37 minutes *2 minutes to acknowledge - 10/07/2025 10:00 p.m. - 98 minutes *26 minutes to acknowledge - 10/08/2025 7:52 a.m. - 100 minutes *12 minutes to acknowledge - 10/08/2025 10:43 a.m. - 81 minutes *10 minutes to acknowledge - 10/10/2025 4:47 p.m. - 62 minutes *4 minutes to acknowledge - 10/11/2025 4:50 p.m. - 50 minutes *8 minutes to acknowledge - 10/11/2025 9:56 p.m. - 100 minutes *17 minutes to acknowledge - 10/12/2025 5:42 a.m. - 209 minutes *Less than 1 minute to acknowledge - 10/12/2025 6:31 p.m. - 47 minutes *13 minutes to acknowledge - 10/13/2025 9:48 a.m. - 31 minutes *5 minutes to acknowledge - 10/15/2025 12:42 p.m. - 36 minutes *1 minute to acknowledge - 10/15/2025 3:28 p.m. - 46 minutes *2 minutes to acknowledge - 10/17/2025 5:50 a.m. - 153 minutes *6 minutes to acknowledge - 10/17/2025 7:27 p.m. - 73 minutes *10 minutes to acknowledge - 10/18/2025 7:25 a.m. - 232 minutes *13 minutes to acknowledge	N 425		

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N 425	Continued From page 16 - 10/18/2025 12:33 p.m. - 37 minutes *1 minute to acknowledge - 10/18/2025 1:41 p.m. - 96 minutes *35 minutes to acknowledge - 10/19/2025 12:20 a.m. - 359 minutes *14 minutes to acknowledge - 10/19/2025 3:19 p.m. - 220 minutes *27 minutes to acknowledge - 10/20/2025 6:49 p.m. - 30 minutes *1 minute to acknowledge - 10/26/2025 12:54 a.m. - 46 minutes *1 minute to acknowledge - 10/26/2025 3:35 a.m. - 55 minutes *34 minutes to acknowledge - 10/26/2025 11:07 p.m. - 34 minutes *4 minutes to acknowledge - 10/31/2025 3:35 a.m. - 34 minutes *33 minutes to acknowledge - 11/01/2025 3:54 a.m. - 39 minutes *1 minute to acknowledge - 11/01/2025 6:40 a.m. - 33 minutes *8 minutes to acknowledge - 11/02/2025 8:44 a.m. - 54 minutes *Less than 1 minute to acknowledge - 11/03/3035 4:29 a.m. - 62 minutes *1 minute to acknowledge On 11/03/2025 at approximately 2:00 p.m., Surveyor interviewed Resident 1. Resident 1 stated s/he used his/her call light daily and that sometimes it took a while for staff to respond. Resident 1 did not define "a while." On 11/03/2025 at approximately 3:00 p.m., Surveyor reviewed call light response concerns with Executive Director A and Regional Director B. Executive Director A stated it was the responsibility of the resident care coordinator to	N 425		

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N 425	Continued From page 17 review call light responses. Executive Director A stated s/he had clarified with the resident care coordinator that long call light response times were followed up on, but only verbally so Executive Director A had no documentation explaining the long wait times. Executive Director A stated the long wait times were likely due to poor time management. On 11/04/2025 at 4:15 p.m., Surveyor requested clarification from Executive Director A regarding acknowledgement time and response time. On 11/04/2025 at 4:40 p.m., Executive Director A explained that call light notifications alert to a walkie talkie. Caregivers could acknowledge the alert on the walkie talkie but would continue to be notified of the call until it was fully resolved, which occurred by using a magnet on the back of their nametag or directly through the walkie talkie.	N 425		
N 439	83.39(1) Infection control program. The licensee shall establish and follow an infection control program based on current standards of practice to prevent the development and transmission of communicable disease and infection. This Rule is not met as evidenced by: Based on observation and interview, the provider did not follow an infection control program based on current standards of practice to prevent the development and transmission of communicable disease and infection.	N 439		

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N 439	Continued From page 18 Resident 3 was observed with his/her catheter bag resting on the floor. Findings include: On 11/03/2025 at 11:45 a.m., Surveyor observed Caregiver F push Resident 3 into the dining room in his/her wheelchair for lunch. Resident 3 had a catheter bag attached to the wheelchair. The catheter bag was dragging on the floor. On 11/03/2025 at 12:30 p.m., Surveyor observed Caregiver F push Resident 3 out of the dining room into another room to watch television. Resident 3's catheter bag was still dragging on the floor. On 11/03/2025 at 1:17 p.m., Surveyor interviewed Caregiver F and asked about caring for residents with catheters. Caregiver F indicated staff should always watch to make sure the catheter bag is not dragging on the floor. Caregiver F indicated the catheter bags can be flimsy, so they must be readjusted on wheelchairs periodically. On 11/03/2025 at 2:05 p.m., Surveyor observed Caregiver F push Resident 3 into the dining room for an activity. Resident 3's catheter bag was still dragging on the floor. The Centers for Disease Control and Prevention (CDC) provides guidance for preventing catheter-associated urinary tract infections. In part, this guidance states, "Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor" (https://www.cdc.gov/infection-control/media/pdfs/Guideline-CAUTI-H.pdf).	N 439		

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N 439	Continued From page 19 On 11/03/2025 at approximately 3:00 p.m., Surveyor shared observation of Resident 3's catheter bag dragging on the floor with Executive Director A and Regional Director B. Executive Director A made note of Surveyor's concern. The provider did not ensure staff followed their infection control program.	N 439		
N 488	83.44(1)(c) Clothes dryers enclosed and vented Clothes dryers. The CBRF shall enclose any clothes dryer having a rated capacity of more than 37,000 Btu/hour in a one-hour fire resistive rated enclosure. If the clothes dryer requires a vent, the CBRF shall use dryer vent tubing that is of rigid material with a fire rating that exceeds the temperature rating of the dryer. The dryer vent tubing shall be clean and maintained. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 2 of 2 dryer vents were made of rigid material. Findings include: On 11/03/2025 at approximately 1:00 p.m., Surveyor toured the provider's facility. Surveyor observed 2 of 2 dryers were vented with semi-rigid material. On 11/03/2025 at approximately 3:00 p.m., Surveyor shared observation of semi-rigid vents with Executive Director A and Regional Director B. Regional Director B acknowledged the need for	N 488		

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N 488	Continued From page 20 vents to made of rigid material. Executive Director A made note of Surveyor's concern.	N 488		