STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014804	A. BUILDING: _____ B. WING _____	R 11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SENIOR LIVING RCAC- VERONA	1125 N EDGE TRAIL 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
{U 000}	INITIAL COMMENTS On 11/03/2025, Surveyors conducted a verification visit at Charter Senior Living RCAC - Verona, a RCAC in Verona. Two deficiencies were identified. Both deficiencies were repeat deficiencies - See Statement of Deficiency (SOD) RYYG11, dated 06/30/2025. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 33	{U 000}		
{U 134}	89.23(4)(d)1. SERVICES PROVIDER QUALIFICATIONS. Staff training. All facility staff shall have training in safety procedures, including fire safety, first aid, universal precautions and the facility's emergency plan, and in the facility's policies and procedures relating to tenant rights. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 6 caregivers reviewed had training in safety procedures, including first aid, fire safety and universal precautions. Caregiver F had not received training in first aid, fire safety or universal precautions.	{U 134}		

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
	0014804	A. BUILDING: _____ B. WING _____	R 11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SENIOR LIVING RCAC- VERONA	1125 N EDGE TRAIL 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
{U 134}	Continued From page 1 Caregiver G worked prior to receiving training in first aid, fire safety or universal precautions. This is a repeat deficiency. See Statement of Deficiency (SOD) RYYG11, dated 06/30/2025. Findings include: On 11/03/2025 at approximately 9:00 a.m., Surveyor reviewed employee records provided by Executive Director D, which documented the following: - Caregiver F was hired on 10/15/2025. Caregiver F's record did not include training for first aid, fire safety or universal precautions. The records indicated Caregiver F was scheduled to receive fire safety training on 11/04/2025. The provider's schedule indicated Caregiver F worked overnight shifts on 11/01/2025 and 11/02/2025 by him/herself without being fully trained. - Caregiver G was hired on 10/16/2025. Caregiver G received universal precaution training on 11/03/2025, fire safety on 11/04/2025 and first aid on 11/05/2025. The provider's schedule indicated Caregiver G worked 10/28/2025, 10/29/2025, 10/30/2025, 11/01/2025 and 11/02/2025 without being trained. The record indicated Caregiver G worked independently during the shifts and was not shadowing or training with another caregiver. On 11/03/2025 at approximately 10:00 a.m., Surveyor reviewed concern with Executive Director D that caregivers were not trained in safety procedures prior to working as a caregiver. Executive Director D reviewed the employee record and confirmed Surveyor's concern. Executive	{U 134}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014804	A. BUILDING: _____ B. WING _____	R 11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SENIOR LIVING RCAC- VERONA	1125 N EDGE TRAIL 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
{U 134}	Continued From page 2 Director D stated Caregiver F was scheduled to receive trainings this week.	{U 134}		
{U 211}	89.28(6) RISK AGREEMENT UPDATING. The risk agreement shall be updated when the tenant's condition or service needs change in a way that may affect risk, as indicated by a review and update of the comprehensive assessment, by a change in the service agreement or at the request of the tenant or facility. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 tenants reviewed had an updated risk agreement. Tenant 1 did not have a risk agreement related to his/her occasional weeping sores to the lower extremities and catheter care. Tenant 2 did not have a risk agreement regarding his/her activated HCPOA. This is a repeat deficiency. See Statement of Deficiency (SOD) RYYG11, dated 06/30/2025. Findings include: On 11/03/2025 at approximately 10:00 a.m., Surveyor reviewed Tenant 2 and Tenant 3's records, which documented the following: - Tenant 1 was admitted to the provider's complex on 06/23/2025. Tenant 1's service plan, dated	{U 211}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014804	A. BUILDING: _____ B. WING _____	R 11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SENIOR LIVING RCAC- VERONA	1125 N EDGE TRAIL 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
{U 211}	Continued From page 3 06/23/2025, indicated s/he was diabetic, had occasional weeping sores to the lower extremities and required catheter cares. - Tenant 2 was admitted to the provider's complex on 02/28/2024. Tenant 2's service plan, dated 10/24/2025, indicated Tenant 2 had a diagnosis of neurocognitive disorder and had an activated Health Care Power of Attorney (HCPOA). Both Tenant 2 and Tenant 3's records included a signed "Risk Acknowledgement" form that stated, " ...intended to ensure each resident and his or her family is fully aware of, and accepts, the inherent risks associated with residing in an assisted living community, residential care community, personal care home or sheltered-care establishment ... Our care is not one-on-one ... The Community cannot guarantee that it can always prevent another resident from engaging in physical contact with your loved one ... The community cannot guarantee that your loved one will not fall ... The Community cannot guarantee that your loved one will not sustain skin breakdown or skin injuries ... The Community cannot guarantee that your loved one will not leave the community ... The Community cannot guarantee the safety of your loved one's property ... The Community cannot provide complete protection from all risk as our goal is to promote independence, physical and mental well-being, and quality of life ... By signing this Acknowledgement, you simply agree that we do not offer a risk-free environment, and you affirm that you have elected to move your loved one into the Community in full awareness and acceptance of the inherent risks that are beyond our ability to control, that we cannot always reduce those risks, and that we are not responsible for circumstances beyond our reasonable control that may result in	{U 211}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014804	A. BUILDING: _____ B. WING _____	R 11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SENIOR LIVING RCAC- VERONA	1125 N EDGE TRAIL 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
{U 211}	Continued From page 4 injury to a resident or damage to a resident's personal property." On 11/03/2025 at approximately 2:40 p.m., Surveyor discussed concern with Executive Director D and Regional Director E that Tenant 2 did not appear to have an individualized risk agreement regarding his/her occasional weeping sores and use of a catheter and Tenant 3 did not have an individualized risk agreement regarding his/her activated HCPOA. Regional Director E acknowledged Surveyor's concern and replied, "I understand if this is a repeat tag." Regional Director E confirmed the "Risk Acknowledgement" form was signed by all residents and did not specify individual risks. Regional Director E stated the provider needed to work with their information technology staff to find a way to individualize the risk agreements.	{U 211}		