STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525695	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anna John Resident Centered Care Community	2901 South Overland Road Oneida, WI 54155

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and record review, the facility did not ensure food was stored and prepared in a sanitary manner. This practice had the potential to affect all 42 residents residing in the facility.Ceiling vents, ceiling tiles, and a ceiling grid above the steam table and where clean dishes were stored contained dust particles and dark-colored debris. Cooking equipment contained dust, debris, and dried food particles. The temperature of the water mixed with sanitizing solution in the three-compartment sink and sanitizing buckets was not checked prior to testing parts per million (PPM) of the solution.Findings include: Ceiling Vents/Tiles/Grid and Equipment: The 2022 Food and Drug Administration (FDA) Food Code documents at 6-202.12 Heating, Ventilating, Air Conditioning System Vents: Heating and air conditioning system vents that are not properly designed and located may be difficult to clean and result in the contamination of food, food preparation surfaces, equipment, or utensils by dust or other accumulated soil from the exhaust vents. The 2022 FDA Food Code documents at 6-501.14 Cleaning Ventilation Systems, Nuisance and Discharge Prohibition: (A) Intake and exhaust air ducts shall be cleaned and filters changed so they are not a source of contamination by dust, dirt, and other materials The 2022 FDA Food Code documents at 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils: Equipment, utensils, and linens shall be clean to sight and touch .(B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. On 2/26/26 at 9:02 AM, Surveyor conducted an initial tour of the kitchen and noted ceiling tiles and a metal grid that held tiles above the steam table and in an area where clean dishes, including cutting boards, frying pans, steam table bins, bread pans, and other cookware were stored, contained dust particles. Under the ceiling vents in the steam table area, Surveyor observed plastic covers used to cover plated food served to residents. Surveyor also observed dark areas with dust adhered to them on ceiling vents near the steam table. On 2/16/26 at 9:15 AM, Surveyor observed a grease-like film that contained dust and debris on the sides of equipment used to cook and fry food. On 2/16/26 at 11:15 AM, Surveyor interviewed [NAME] (CK)-G who was not sure how often the ceiling was cleaned but stated new ceiling tiles were installed a couple months ago. On 2/16/26 at 1:00 PM, Surveyor interviewed CK-I who confirmed the steam table under the ceiling grid, tiles, and vents that contained debris was the main steam table where cooked food was held and plated for residents. On 2/16/26 at 1:05 PM, Surveyor interviewed Registered Dietitian (RD)-F who stated the facility follows the Federal (FDA) Food Code. RD-F indicated the dark areas on the ceiling vents were from wear. Upon further observation, RD-F confirmed the ceiling tiles and vents contained dust. RD-F stated maintenance staff or RD-F cleaned the ceiling every couple of months. On 2/16/26 at 2:00 PM, Surveyor observed RD-F clean the ceiling tiles and vents and the equipment used to cook/fry food. Surveyor noted there was no dark-colored debris or dust particles where RD-F had cleaned. RD-F confirmed the dark area areas wiped off and were not due to wear. On 2/17/26 at 7:50 AM, RD-F provided Surveyor with a cleaning schedule. RD-F stated RD-F added cleaning the ceiling on a monthly basis and indicated the ceiling had been cleaned every 3 months prior. The cleaning schedule (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	also included an entry for cleaning equipment. Sanitizing Solution: The 2022 FDA Food Code documents as 4-501.114 Manual and Mechanical Ware Washing Equipment, Chemical Sanitization - Temperature, pH, Concentration, and Hardness: A chemical sanitizer used in a sanitizing solution for a manual or mechanical operation at contact times specified under 4-703.11(C) shall meet the criteria specified under 7-204.11 Sanitizers, Criteria, shall be used in accordance with the Environmental Protection Agency (EPA)-registered label use instructions, and shall be used as follows: .C) A quaternary ammonium compound solution shall: (1) Have a minimum temperature of 24 degrees Celsius (C) (75 degrees Fahrenheit (F)), (2) Have a concentration as specified under 7-204.11 and as indicated by the manufacturer's use directions included in the labeling . On 2/16/26 at 12:30 PM, Surveyor reviewed instructions on the Hydrian Quat Dispenser test strip container which stated to dip a strip into the sanitizing solution for 10 seconds and instantly compare the resulting color with the enclosed color chart which matched concentrations of 0-100; 100-200; 200-300; and 300-400 PPM. The container indicated the solution should be between 65 and 75 degrees F when tested. On 2/16/26 at 12:45 PM, Surveyor noted the three-compartment sink and a red bucket with a dish cloth near the sink were filled with water and sanitizing solution. Surveyor reviewed a PPM log located near the sink that contained the month, day, and a column for PPM. The form did not include a space for temperature. On 2/16/26 at 1:00 PM, Surveyor interviewed CK-H who stated the three-compartment sink is used to wash large dishes used for food preparation that do not fit in the dishwashing machine. CK-H stated the solution in the red bucket is used to wipe surfaces in the kitchen, including counters where food is prepared. CK-H confirmed litmus Hydrian test strips near the sink are used to check PPM of the sanitizing solution. CK-H stated the range the litmus should indicate for sanitizer efficacy and confirmed the facility uses Quat sanitizer. CK-H stated the temperature of the water mixed with sanitizing solution in the three-compartment sink and red bucket is not checked when PPM are tested. When Surveyor showed CK-H the instructions for testing PPM which indicated the water temperature should be between 65 and 75 degrees, CK-H stated CK-H tests the solution when the water is luke warm. CK-H confirmed CK-H does not use a thermometer to test the temperature. On 2/17/26 at 10:55 AM, Surveyor interviewed CK-G who stated the temperature of water used in the three-compartment sink is not checked with a thermometer when PPM are tested. On 2/17/26 at 8:52 AM, Surveyor interviewed RD-F who confirmed the temperature of the water mixed with the sanitizing solution is not checked when PPM are tested in the three-compartment sink or the bucket used to clean kitchen and food prep surfaces.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident?s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not complete Quarterly Minimum Data Set (MDS) assessments within the required timeframe for 5 residents (R) (R23, R25, R32, R42, and R43) of 42 sampled residents. Review of the facility's MDS assessment submission indicated the following: ~ R23's Quarterly MDS assessment, due December 2025, was not completed.~ R25's Quarterly MDS assessment, due September 2025, was not completed.~ R32's Quarterly MDS assessment, due August 2025, was not completed.~ R42's Quarterly MDS assessments, due March 2025 and September 2025, were not completed.~ R43's Quarterly MDS assessments, due February 2025 and May 2025, were not completed. Findings include: The Resident Assessment Instrument (RAI) Manual, revised October 2025, indicates: .Assuming the resident did not experience a significant change in status, was not discharged , and did not have a Significant Correction to Prior Comprehensive Assessment (SCPA) completed, assessment scheduling would then move through a cycle of three Quarterly assessments followed by an Annual (Comprehensive) assessment .An Omnibus Budget Reconciliation Act (OBRA) assessment (Comprehensive and Quarterly) is due every quarter unless the resident is no longer in the facility. There must be no more than 92 days between OBRA assessments. From 2/16/26 to 2/18/26, Surveyor reviewed R23's medical record. R23 was admitted to the facility on [DATE]. R23 had an MDS assessment (Comprehensive) completed on 9/10/25. R23's next Quarterly MDS assessment (due December 2025) was not completed. From 2/16/26 to 2/18/26, Surveyor reviewed R25's medical record. R25 was admitted to the facility on [DATE]. R25 had an MDS assessment (Comprehensive) completed on 6/25/25. R25's next Quarterly MDS assessment (due September 2025) was not completed. From 2/16/26 to 2/18/26, Surveyor reviewed R32's medical record. R32 was admitted to the facility on [DATE]. R32 had an MDS assessment (Comprehensive) completed on 5/9/25. R25's next Quarterly MDS assessment (due August 2025) was not completed. From 2/16/26 to 2/18/26, Surveyor reviewed R42's medical record. R42 was admitted to the facility on [DATE]. R42 had an MDS assessment (Comprehensive) completed on 11/29/24. R42's next Quarterly MDS assessments (due March 2025 and September 2025) were not completed. From 2/16/26 to 2/18/26, Surveyor reviewed R43's medical record. R43 was admitted to the facility on [DATE]. R43 had an MDS assessment (Quarterly) completed on 11/27/24. R43's next Quarterly MDS assessments (due February 2025 and May 2025) were not completed. On 2/18/26 at 8:17 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who stated the facility outsourced MDS assessments to a contracted agency in July of 2025. NHA-A acknowledged inaccuracies in the MDS assessments and was aware discrepancies were identified with the contracted agency's completion of the assessments. On 2/18/26 at 8:20 AM, Surveyor interviewed MDS Registered Nurse (RN)-J who stated the contracted agency initiates all MDS assessments, has access to residents' medical records, and completes the nursing sections based on information provided by RN-J, including a history and physical and discharge summary. RN-J stated RN-J transmits the assessments when the contracted agency indicates the assessments are complete.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure timely transmittal of Resident Assessment Information (RAI)/Minimum Data Set (MDS) assessments for 18 residents (R) (R51, R19, R52, R16, R53, R54, R55, R23, R31, R34, R35, R43, R9, R40, R42, R56, R50, and R26) of 49 sampled residents (42 residents who currently resided in the facility and 7 residents who were discharged). The facility did not timely transmit RAI/MDS assessments for R51, R19, R52, R16, R53, R54, R55, R23, R31, R34, R35, R43, R9, R40, R42, R56, R50, and R26. Findings include: The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.17.1, dated October 2025, indicates: All Medicare and/or Medicaid-certified nursing homes must transmit required MDS records to the Centers for Medicare and Medicaid Services (CMS) .Required MDS records include Admission, Quarterly, Annual, Discharge assessments and entry tracking records .Transmitted means electronically transmitting an MDS record that passes CMS' standard edits and is accepted into the system within 14 days of the assessment reference date (ARD) (last day of the resident assessment period). From 2/16/26 to 2/18/26, Surveyor reviewed the facility's MDS submissions and noted the following: ~ R51 was admitted to the facility on [DATE] and discharged on 5/16/25. The facility did not transmit a Discharge-Return Not Anticipated MDS assessment until 2/18/26.~ R19 was admitted to the facility on [DATE] and discharged on 8/30/25. The facility did not transmit a Discharge-Return Not Anticipated MDS assessment until 2/18/26.~ R52 was admitted to the facility on [DATE] and discharged on 6/28/25. The facility did not transmit a Discharge-Return Not Anticipated MDS assessment until 2/18/26.~ R16 was due for a Comprehensive MDS assessment on 10/26/25. The facility completed the assessment on 10/28/25 and transmitted the assessment on 10/31/25.~ R53 was admitted to the facility on [DATE] and discharged on 1/31/25. The facility did not transmit a Discharge-Return Not Anticipated MDS assessment until 2/27/26.~ R54 was due for a Comprehensive MDS assessment on 11/13/25. The facility completed the assessment on 11/14/25 and transmitted the assessment on 11/19/25.~ R55 passed away at the facility on 1/25/25. The facility did not transmit a Death Tracking MDS assessment.~ R23 was admitted to the facility on [DATE] and was due for an admission MDS assessment on 9/7/25. The facility completed the assessment on 9/12/25 and transmitted the assessment on 9/24/25.~ R31 was admitted to the facility on [DATE] and was due for an admission MDS assessment on 11/2/25. The facility completed the assessment on 11/4/25 and transmitted the assessment on 11/5/25.~ R34 was admitted to the facility on [DATE] and was due for an admission MDS assessment on 1/1/26. The facility completed the assessment on 1/2/26 and transmitted the assessment on 1/5/26.~ R35 was admitted to the facility on [DATE] and was due for a Comprehensive MDS assessment on 10/16/25. The facility completed the assessment on 10/18/25 and transmitted the assessment on 10/28/25.~ R43 was hospitalized on [DATE]. The facility completed a Discharge-Return Anticipated MDS assessment. The facility did not complete a Reentry Tracking MDS assessment upon R43's return to the facility.~ R9 was due for a Quarterly MDS assessment on 8/18/25. The facility completed the assessment on 8/20/25 and transmitted the assessment on 8/21/25.~ R40 was due for a Quarterly MDS assessment on 8/7/25. The facility completed the assessment on 8/11/25 and transmitted the assessment on 8/13/25.~ R42 was hospitalized on [DATE]. The facility did not transmit a Discharge MDS assessment.~ R56 was admitted to the facility on [DATE]. The facility did not transmit an Entry Tracking MDS assessment.~ R50 was admitted to the facility on [DATE]. The facility completed an admission MDS assessment on 1/30/25 and transmitted the assessment on 3/6/26.~ R26 was admitted to the facility on [DATE]. R26 was due for an Annual MDS assessment on 12/27/25. The facility completed the assessment on 12/31/25 and transmitted the assessment on 2/27/26. On 2/18/26 at 8:17 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who stated the facility outsourced the completion of MDS (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assessments to a contracted agency in July of 2025. NHA-A acknowledged inaccuracies in the MDS assessments and was aware discrepancies were identified with the contracted agency's completion of the assessments. On 2/18/26 at 8:20 AM, Surveyor interviewed MDS Registered Nurse (RN)-J who stated the contracted agency initiates all MDS assessments, has access to residents' medical records, and completes the nursing sections based on information provided by RN-J, including a history and physical and a discharge summary. RN-J stated RN-J transmits the assessments to iQIES when the contracted agency indicates the assessments are complete. RN-J was unsure why some assessments were not transmitted timley or not transmitted at all.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not accurately code Minimum Data Set (MDS) 3.0 assessments for 4 residents (R) (R14, R2, R43, and R49) of 42 sampled residents. R14 was admitted to the facility on [DATE]. R14 was hospitalized on [DATE] and readmitted to the facility on [DATE]. R14's Tracking MDS assessment, dated 7/21/25, did not contain the correct admission date or entry type. R2's MDS assessment, dated 1/6/26, indicated R2 received Hospice services. R2 did not receive Hospice services in the facility. R43 had diagnoses of schizoaffective disorder and post-traumatic stress disorder (PTSD). R43's MDS assessments, with ARDs of 7/11/25 and 10/20/25, did not contain the diagnoses. R49 was admitted to the facility on [DATE]. R49's Tracking MDS assessment, dated 4/16/25, indicated the entry type was Rentry instead of Admission. Findings include: 1. From 2/16/26 to 2/18/26, Surveyor reviewed R14's medical record. R14 was admitted to the facility on [DATE]. R14 was hospitalized on [DATE] and returned to the facility on 7/21/25. R14's Tracking MDS assessment, dated 7/21/25, indicated the admission Date was 7/21/25 (instead of 10/17/24) and the entry type was admission (instead of Reentry). On 2/18/26 at 8:17 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who stated the facility outsourced MDS assessments to a contracted agency in July of 2025. NHA-A acknowledged inaccuracies in the MDS assessments and was aware discrepancies were identified with the contracted agency's completion of the assessments. On 2/18/26 at 8:20 AM, Surveyor interviewed MDS Registered Nurse (RN)-J who stated the contracted agency initiates all MDS assessments, has access to residents' medical records, completes the nursing sections based on information provided by RN-J, including a history and physical and a discharge summary. 2. From 2/16/26 to 2/18/26, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] from another nursing facility and signed off of Hospice services prior to admission. R2's MDS assessment, dated 1/6/26, indicated R2 received Hospice services at the facility. On 2/18/26 at 10:13 AM, Surveyor interviewed NHA-A who confirmed R2's MDS assessment was inaccurate. NHA-A stated the facility had an in-house comfort care program which R2 was signed up for; however, the facility was not a licensed Hospice provider. 3. From 2/16/26 to 2/18/26, Surveyor reviewed R43's medical record. R43 was admitted to the facility on [DATE] and had diagnoses of schizoaffective disorder and PTSD. R43's MDS assessments, dated 7/11/25 and 10/20/25, did not indicate R43 had diagnoses of schizoaffective disorder and PTSD. On 2/18/26 at 10:13 AM, Surveyor interviewed NHA-A who confirmed R43 had diagnoses of schizoaffective disorder and PTSD which should have been reflected on the MDS assessment. 4. From 2/16/26 to 2/18/26, Surveyor reviewed R49's medical record. R49 was admitted to the facility on [DATE]. A Discharge-Return Anticipated MDS assessment, completed by the facility on 3/13/20, indicated R49 had a planned discharge to the community on 3/13/20. R49's Tracking MDS assessment, dated 4/16/25, indicated the entry type was Reentry (instead of Admission). On 2/18/26 at 8:17 AM, Surveyor interviewed NHA-A who stated the facility outsourced MDS assessments to a contracted agency in July of 2025. NHA-A acknowledged inaccuracies in MDS assessments and was aware of discrepancies identified with the contracted agency's completion of the assessments. On 2/18/26 at 8:20 AM, Surveyor interviewed MDS RN-J who stated the contracted agency initiates all MDS assessments, has access to residents' medical records, and completes the nursing sections based on information provided by RN-J, including a history and physical and a discharge summary.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not ensure appropriate respiratory care and services were provided for 1 resident (R) (R8) of 1 sampled resident. R18 had a continuous positive airway pressure (CPAP) machine (a device that treats obstructive sleep apnea (OSA) by keeping the airway open). R8's medical record did not contain a diagnosis of OSA or orders for the use, care, and maintenance of the machine. Findings include:The facility's CPAP/BiPAP Usage in Long-Term Care policy indicates: To ensure residents requiring CPAP or BiPAP receive, maintain, and are monitored for their prescribed therapy to ensure safety, compliance with medical necessity, and optimal respiratory function .Upon admission, identify if the resident uses a CPAP/BiPAP device for obstructive sleep apnea (OSA) or other pulmonary disorders .Obtain a current physician order specifying the type of machine (CPAP/BiPAP), pressure settings .and oxygen flow rate (if applicable) .Ensure a copy of a recent sleep study, if available, is in the chart to support medical necessity .The facility will ensure the machine is in good working order. Any defects must be reported to the Durable Medical Equipment (DME) provider immediately .Use distilled water for the humidifier to prevent mineral buildup .Comfort Settings: These are pre-set and sent to nursing home once sleep study is complete .Mask Fit: Ensure a proper seal to prevent air leaks into the eyes or significant pressure loss .Monitoring and Care .Staff will document daily on the Treatment Administration Record (TAR) the hours of usage and any issues with compliance .Inspect the bridge of the nose and facial areas daily for pressure sores caused by the mask .Cleaning and Infection Control: Daily: Clean the mask and tubing with mild soap and water or follow manufacturer guidelines; Weekly: Thoroughly clean the water chamber and humidifier, allowing all parts to dry; COVID-19/Respiratory Infection: If a resident is suspected of having COVID-19 or another respiratory virus, CPAP/BiPAP therapy should be re-evaluated by a physician, as these are aerosol-generating procedures .Replace masks, tubing, and filters according to the established manufacturer/insurance schedule (e.g., masks every 3 months, cushions twice a month) .Mask Leaks: Adjust headgear straps and check for cracks in the tubingBetween 2/16/26 and 2/18/26, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE]. R8's Quarterly Minimum Data Set (MDS) assessment, dated 1/8/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R8 had intact cognition. R8 was R8's own decision maker. A hospital Discharge summary, dated [DATE], indicated R8 had a sleep study and had OSA/obesity hypoventilation syndrome ([NAME]). It was unclear if R8 was on device therapy for OSA/[NAME] at home. A physician note, dated 2/7/26, indicated: Problem #5: Sleep apnea .Has OSA. CPAP pending. R8's medical record did not contain a diagnosis, physician order, or care plan for use of a CPAP machine. R8's medical record also did not contain monitoring or assessments for use of the machine or instructions for cleaning and maintenance of the machine. On 2/16/26 at 11:54 AM and 2/18/26 at 1:41 PM, Surveyor interviewed R8 and asked about the CPAP machine on R8's nightstand. R8 stated R8 was diagnosed with sleep apnea and used the CPAP machine at night. Surveyor noted the mask and tubing were connected to the machine. Surveyor observed a partially used gallon of distilled water on the ground next to the nightstand. When asked how staff take care of and clean the machine, R8 stated staff clean the mask and tubing two to three times per week. R8 stated the doctor who ordered the CPAP machine told R8 to fill the reservoir with distilled water and clean the machine two to three times per week. R8 stated R8 obtained the CPAP machine after a sleep test in the facility approximately a month ago. R8 stated R8 uses the CPAP machine every night and staff help R8 remove the mask in the morning. On 2/18/26 at 2:08 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Registered Nurse (RN)-D. NHA-A reviewed R8's hospital discharge summary which mentioned OSA/[NAME] but could not find further documentation for R8's OSA/[NAME] and CPAP machine. RN-D could not find documentation for R8's CPAP machine except a document from an appointment, dated 9/30/25, with a note for an overnight (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sleep study that indicated: Will be contacted with next steps when more information is available. NHA-A reviewed R8's medical record and could not find documentation for a CPAP or OSA like-diagnosis for R8 or instructions for care of the machine.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, staff interview, and record review, the facility did not maintain an infection prevention and control program designed to prevent the transmission of communicable disease and infection for 2 residents (R) (R47 and R12) of 2 residents observed during COVID-19 testing. Registered Nurse (RN)-E did not change a disposable gown between COVID-19 antigen nasal swab tests for R47 and R12. Findings include:According to the Centers for Disease Control and Prevention (CDC) website https://www.cdc.gov/niosh/healthcare/hcp/pandemic/conserving-isolation-gowns.html retrieved 2/19/26, the Strategies for Conserving the Supply of Isolation Gowns, dated 10/22/24, provides guidance to conserve the supply of isolation gowns in healthcare settings when there is limited supply due to increased use and demand (e.g., as may occur during an infectious disease pandemic or epidemic) or supply chain disruption.The CDC website https://www.cdc.gov/niosh/healthcare/hcp/pandemic/conserving-PPE-shortages.html retrieved 2/19/26, Conserving Supplies of Personal Protective Equipment in Healthcare Facilities During Shortages, dated 10/22/24, indicates: .Healthcare facilities should promptly resume conventional capacity practices as soon as practical and by the time personal protective equipment (PPE) supplies increase .The facility did not have a current policy and procedure for the reuse of PPE. Upon entrance to the facility on 2/16/26 at 8:00 AM, a posting indicated the facility was in a COVID-19 outbreak. On 2/17/26 at 11:31 AM, Surveyor observed RN-E complete COVID-19 antigen testing (swabbing of both nasal passages) for R47 and R12. RN-E wore a disposable isolation gown in addition to a surgical mask, eye protection, and gloves. RN-E entered R47's room, swabbed R47's left and right nasal passages, and set the COVID-19 test on a cart used for supplies. RN-E removed gloves and washed hands but did not remove the disposable gown. RN-E then donned clean gloves, entered R12's room, swabbed R12's right and left nasal passages, and set the COVID-19 test on the cart. RN-E removed gloves and completed hand hygiene. Immediately after the observations, Surveyor interviewed RN-E who stated RN-E was conducting COVID-19 testing that day. RN-E stated RN-E could wear the same gown throughout the testing unless a resident was on droplet precautions which required RN-E to dispose of the gown and gloves after the COVID-19 test.On 2/17/26 at 12:02 PM, Surveyor interviewed Infection Preventionist (IP)-C who stated staff wear the same reusable isolation gown when testing residents for COVID-19 unless a resident is symptomatic or on transmission based recautions (TBP) (contact, droplet, airborne which would require the use of specific PPE like a gown, gloves, mask, and eye protection) in which case they should change gowns between each resident. On 2/17/26 at 1:37 PM, IP-C informed Surveyor that the facility did not have a policy for the reuse of disposable isolation gowns. IP-C stated at one point during the COVID-19 pandemic, the facility might have practiced extended use of disposable gowns by reusing disposable gowns due to PPE shortages. IP-C stated the facility was not currently in a PPE shortage. On 2/18/26 at 11:28 AM, Surveyor interviewed Interim Director of Nursing (DON)-B who stated staff have reused disposable gowns since the beginning of COVID-19 for testing unless a resident is on TBP. DON-B verified the practice was outdated and stated the the facility would change it.