STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145664	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Axiom Healthcare of West Frankfort	601 North Columbia West Frankfort, IL 62896

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40666 Based on observation and record review, the facility failed to notify the proper authorities in an abuse investigation in 1 (R14) of 1 resident reviewed for abuse. The findings include: R14's Admission Record documented admission to the facility on [DATE] and included diagnoses of peripheral vascular disease, heart failure, Type 2 Diabetes Mellitus, chronic pressure ulcers on right buttock, stage 3, non-pressure related chronic ulcers of left heel and mid foot and left lower leg. R14's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, indicating R14 is cognitively intact. The facility's Report to IDPH Regional Office documented an initial report dated 3/10/25, noting there was an allegation of staff to resident abuse (verbal). Actions taken included the CNA's (Certified Nurse Assistant's) in question were suspended, the physician and Power of Attorney (POA) were notified on 3/10/25. The document also notes an investigation was initiated. There was no documentation on the Initial Report to show that the Local Police were notified. The facility's Report to IDPH Regional Office doucmented a Final Report was submitted on 3/13/25 and noted R14 reported to dayshift CNA that the night shift CNA's were rude to him and that they took his laptop away from him. This report has sections to note if Resident Representative/Family and Physician are notified and those sections are marked Yes. The document does not include a section to note whether law enforcement is notified and the report does not include this information. On 3/13/25 at 2:30PM, after being asked if the facility notified law enforcement, V1 (Regional Director of Operations) stated she did not notify the police. The facility document titled Abuse Prevention and Reporting-Illinois Effective date 11-28-16, revised 10/24/22 documented the purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. This will be done by .Filing accurate and timely investigative reports .Informing Local Law Enforcement. The facility shall also contact local law enforcement authorities (i.e., telephoning 911 where available) in the following situations: (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physical abuse involving physical injury inflicted on a resident by a staff member or a visitor. Physical abuse involving physical injury inflicted on a resident by another resident except in situations where the behavior is associated with dementia or developmental disability. Sexual abuse of a resident by a staff member, another resident, or visitor. When there is a reasonable suspicion that a crime has been committed in the facility by a person other than a resident. When a resident death has occurred other than by disease processes.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36384 Based on observation, interview and record review, the facility failed to ensure that dietary supplements were provided to residents as ordered for 4 (R4, R13, R19, and R20) of 4 residents reviewed for nutrition status in the sample of 27. The Findings Include: 1. R4's Admission Record documents an admission to the facility on [DATE] and included the following diagnoses: dementia, Vitamin D deficiency and Vitamin B12 deficiency. R4's current Physician Orders for diet are as follows: regular diet and mighty shakes twice a day for low Body Mass Index (BMI). R4's Care Plan has a focus area of: I have a potential nutritional problem. A goal for this focus area included: I will maintain adequate nutritional status daily through the review date. The interventions include: provide diet as ordered. 2. R13's Admission Record documents an admitted [DATE] and included the following diagnoses: bipolar disease, anxiety, depression, and muscle wasting and atrophy. R13's current Physician Orders have a diet order of mighty shakes with meals for significant weight loss for 6 months, No added salt diet. R13's Care Plan includes a focus area of: risk for malnutrition. The goal for this focus area is: resident intake of nutrients will meet metabolic needs. Interventions include to provide diet as ordered and a mighty shake at breakfast and supper. 3. R19's Admission Record documents an admission to the facility on [DATE] and included the following diagnoses: unspecified dementia, Alzheimer's disease, and cognitive communication deficit. R19's current Physician Orders include a regular diet and mighty shakes with three meals. R19's Care Plan includes a focus area of: the resident has a potential nutritional problem. The goal listed for this focus area is: The resident will maintain adequate nutritional status as evidenced by maintaining weight, no signs or symptoms of malnutrition, and no indication of issue with diet consistency through the next review. The interventions include the following: mighty shakes three times a day related to weight loss. 4. R20's Admission Record documented an admitted [DATE] and included the following diagnoses: Alzheimer's, anxiety, major depressive disorder, and muscle wasting and atrophy. R20's current Physician Orders include a diet order of regular diet with mighty shakes at meals for encouraging increase in intake with weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R20's Care Plan includes a focus area of: the resident has a potential nutritional problem. The goal for this focus area is: The resident will consume diet in amount adequate to meet nutritional needs as evidenced by maintaining weight with no excessive loss. The interventions include: provide and serve diet as ordered. On 3/11/2025 during the lunch meal observation at 12:00 PM, V5 (Dietary Manager) stated that the truck did not come in until lunch meal service started and the mighty shakes were frozen when delivered. V5 stated that the residents that are ordered mighty shakes did not get them for breakfast or lunch today. At this time, V5 stated that residents who are ordered supplements twice a day get them at breakfast and lunch, residents who have them ordered once a day get them at lunch, and residents who are ordered supplements three times a day get them with each meal. On 3/11/2025 at 2:00 PM, V5 provided a list of residents that are to receive supplements and it listed R4 to receive mighty shakes twice a day, R13 to receive mighty shakes three times a day, R19 to receive mighty shakes three times a day, and R28 to receive mighty shakes once a day.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 49663 Based on interview and record review, the facility failed to ensure Registered Nurse (RN) coverage 8 consecutive hours a day, 7 days per week. This failure has the potential to affect all 40 residents living in the facility. Findings Include: The facility's agency nursing time reports documented no RN was on shift for 11/10/2024, 11/23/2024, 11/24/2024, 11/28/2024, 11/30/2024, 12/7/2024, 12/8/2024, and 12/21/2024. On 3/13/2025 at 7:50 AM, V10 (Licensed Practical Nurse/LPN) stated there were some days in October 2024 - December 2024 that they did not have RN coverage for 8 consecutive hours a day. On 3/13/2025 at 10:05 AM, V2 (Director of Nursing) stated there were no RN punch times noted on the agency nursing reports for 11/10/2024, 11/23/2024, 11/24/2024, 11/28/2024, 11/30/2024, 12/7/2024, 12/8/2024, and 12/21/2024. On 3/13/2025 at 10:30 AM, V1 (Regional Director of Operations) stated the facility did not have documentation of a Registered Nurse on shift for at least 8 consecutive hours a day on 11/10/2024, 11/23/2024, 11/24/2024, 11/28/2024, 11/30/2024, 12/7/2024, 12/8/2024, and 12/21/2024. V1 stated the facility follows the regulations for staffing because they don't have a policy on RN coverage 8 Hours per day/7 days a week. The Long-Term Care Facility Application for Medicare and Medicaid document dated 3/11/2025, documents 40 residents residing in the facility.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40666 Based on interview and record review, the facility failed to ensure behavioral interventions and procedures for suicide observation and prevention were provided to a resident with suicidal ideations for 1 (R23) of 1 resident reviewed for behavioral health services in the sample of 27. The findings include: R23's Admission Record documents that she was admitted to the facility on [DATE] and included diagnoses of major depressive disorder, schizophrenia, borderline personality disorder, anxiety disorder, panic disorder, cognitive communication deficit, vascular dementia, moderate with psychotic disturbance, unspecified sequelae of cerebral infarction and epilepsy. R23's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 11, indicating R23 has moderate cognitive impairment. Under the section for Mood, R23 is documented as having the following symptoms: Little interest or pleasure in doing things, feeling down, depressed, or hopeless, Trouble falling or staying asleep, or sleeping too much, feeling tired or having little energy, poor appetite or overeating, and feeling bad about self - or that you are a failure or have let self or family down. At the time of this assessment, R23 was not documented as having thoughts that she would be better off dead, or of hurting self in some way. Under the section for Behavior, delusions was documented as a potential indicator of psychosis, and the following behavioral symptoms were checked: physical behavioral symptoms directed towards others, verbal behavioral symptoms directed toward others, and other behavioral symptoms not directed toward others which were noted to significantly interfere with the resident's care and the resident's participation in activities or social interactions. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R23's Care Plan documents Focus Areas of Risk for Depression, Behavior Management, R23 uses antidepressant medication, R23 uses antipsychotic medications r/t (related to) Schizophrenia, and R23 may display s/s (signs/symptoms) of depression. Interventions listed for Risk for Depression include to notify provider any risk for harm to self and/or others (initiated 5/9/24) and observe resident for any signs/symptoms of depression, including: hopelessness, anxiety, sadness .verbalizing negative statements, repetitive anxious or health-related complaints and tearfulness (initiated 5/9/24). Interventions listed for Behavior Management include monitor for cognitive factors that may contribute to new behavior(s) and provide emotional support regarding new onset disruptive behavior, refer to SSD (Social Services Director) PRN (as needed (initiated 3/7/25), and utilize diversion techniques as needed (initiated 3/6/25). Interventions listed for R23's use of antidepressant medication include to monitor/document/report PRN adverse reactions to antidepressant therapy: change in behavior/mood/cognition; hallucinations/delusions, social isolation, suicidal thoughts, withdrawal, etc. (initiated 4/4/24). Interventions listed for R23's use of antipsychotic medications r/t diagnosis of schizophrenia include to monitor/document/report PRN any adverse reactions of psychotropic medications: including suicidal ideations, social isolation and behavior symptoms not usual to the person (initiated 4/4/24). Interventions for R23's potential to display s/s of depression include: monitor/document/report PRN any risk for harm to self; suicidal plan, past attempt at suicide, risky actions, intentionally harming or trying to harm self .sense of hopelessness or helplessness, impaired judgement or safety awareness (initiated 4/4/24), monitor/document/report PRN any s/s of depression including hopelessness, anxiety, sadness .verbalizing negative statements, repetitive anxious or health related complaints, tearfulness (initiated 4/4/24), and the resident needs time to talk. Encourage the resident to express feelings (initiated 4/4/24). A Progress Note dated Sunday 3/9/25 at 9:03 PM, documented a behavioral note written by V14 (Agency Licensed Practical Nurse/LPN) noting Resident stated several times per this shift that she wants to kill herself. Writer spoke with resident she had no plan on how she was going to kill herself she just wants to die. Staff monitored resident closely per this shift. There were no other progress notes in the medical record on this date or through the night shift hours documenting whether R23's mood or behavior improved or worsened, no documentation to show a suicide checklist or assessment was completed, no documentation noting the physician had been notified, nor any documentation to show evidence that any follow-up monitoring had been implemented. The next behavioral Progress Note regarding R23's suicidal ideation behavior was dated Monday 3/10/25 at 9:41 AM by V15 (Social Service Assistant/SSA) and documented Was reported per DON (Director of Nursing) that R23 wasn't feeling well this weekend and had made several threats that she wanted to die without a plan. I checked on (R23) twice this morning and she appears to be sleeping I will c/t to monitor (R23) closely and provide 1:1's as needed for safety and comfort. This note also does not document the physician was notified of R23's suicidal ideation behaviors. A Progress Note dated 3/10/25 at 2:53 PM documented a behavior note written by V15 that stated I spoke with (R23); she was calling out. I asked what she was up to. She said she had to pee. I assured her that some (sic) had just helped her and left her room. I assured her I would get someone to help. I asked (R23) what was going on this weekend about her comment about not wanting to live anymore. She shook her head and said, 'I just want someone to take me to poop.' I will c/t monitor Renee's cognitive change. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Suicidal Threat Checklist (No Attempt Has Been Made) was completed by V15 dated 3/10/25, a day after R23 verbalized suicidal threats. This checklist includes 5 tasks/questions, with number 1 stating to check resident's Suicide Potential Assessment (located in Chart). Question #2 - Ask the Resident why they made the threat is answered I don't know I just want someone to take me to poop. #3 - Ask the resident if there is a staff member who can solve the problem and how is answered I want out of this stupid chair. #4 - If staff and resident can't solve the problem does the resident still want to harm himself is answered No, I want someone to take me pee. #5 - Ask the resident if there is a plan to harm himself and what the plan is, is answered I aint got no plan, look at me. The Options document send to hospital, place on 1:1, place on 15 min check, counseling and the items written in are 1:1 Counseling with cognitive behavioral skills building training. Under Risk Level is documented R23 is at low risk due to cognitive and memory impairment. R23 is bed ridden at this time. On Tuesday 3/11/25 at 2:36 PM, V14 documented Writer telephoned NP (Nurse Practitioner) to inform of resident's suicidal threats left message to telephone facility. On 3/13/25 at 3:10PM, V14 (Agency LPN) stated she assessed R23 and did not think she was serious, so she did not notify the Physician. V14 said she did not think to notify the physician (at that time) but did notify them on 3/11/5 at 2:36 PM. V14 said she just kept an eye on R23 that night and did not document any checks. On 3/14/25 at 10:00AM, V2 (Director of Nursing/DON) stated she did not know about R23 having suicidal ideations until she read the note. V2 said that she went to morning meeting (3/10/25) where they discussed it and she asked V15 (SSA) to go talk to R23 and see how she was doing. V2 said the Physician had not been notified. V2 said if she would have known about it at the time it occurred, she would have notified the Physician, implemented every 15-minute checks and ensured Social Service completed a suicide assessment. On 3/14/25 at 11:00AM, V15 (Social Services Assistant) said she was told about R23's suicidal ideations during morning meeting on 3/10/25. V15 said she talked with R23 and also did a suicide assessment in which she determined R23 was not at risk of suicide. V15 said that R23 had forgotten all about it and was hyper focused on toileting and had just went to the bathroom. On 3/14/25 at 11:15AM, V2 (DON) said she did notify the Physician on 3/11/25 and he called back and said to have her seen by Psych. V2 said that R23 was going to be seen anyway on 3/12/25. The facility's undated Suicide Observation and Prevention policy documents the purpose is to protect resident from self-injury or death, to increase resident's control of self-destructive impulse and to provide opportunity to talk about problems. The policy documents the responsibility as nursing personnel and interdisciplinary team members and states It is the policy of the Nursing Department to implement nursing interventions for residents who exhibit suicidal tendencies. Under Procedure, #2 documents Continuous monitoring includes mental and psychosocial status as well as physical and under Rationale/Amplification documents All changes in condition require prompt notification of physician and sponsor/family member. The same document notes .Initiate a monitoring form or document checks every 15 minutes and stay within visual and close access of the resident at all times as determined necessary by Charge Nurse and M.D. (Medical Doctor) until medical psychiatric evaluation indicates it is no longer necessary.

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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. 36384 Based on observation, interview and record review the facility failed to properly maintain the hot water source to reach minimum washing temperatures in the dish machine and handle food properly to prevent cross contamination. These failures have the potential to affect all 40 residents residing in the facility. The Findings Include: 1. On 3/11/25 at 1:00 PM, the kitchen staff were in the process of washing the lunch dishes after the meal was served in the dish machine. When the temperature in the dish machine was checked with a kitchen provided calibrated thermometer, the water temperature was 80 degrees. At this time V5 (Dietary Manager) verified their dish machine was a low temperature dishwasher that uses chemical sanitization. V5 stated that they have trouble sometimes with the water temperatures because of the way the system works. V5 stated that they have two 40 gallon water heaters, but one of them feeds both the three compartment sink and the dish machine. V5 stated that she typically would like the water temperature above 110 degrees Fahrenheit. On 3/11/25 at 2:00 PM, V4 (Maintenance) stated that he thinks that they need to make sure that they don't fill the 3 compartment sink and run the dishwasher at the same time, that is why they are running out of hot water. V4 further stated that he checked it now, and the water was up to 100 degrees Fahrenheit. V4 stated that he will tell the kitchen staff this is new procedure until they have a long term fix. At this time they are hand washing the dishes in the sink with the appropriate water temperature. On 3/12/2024 at 2:00 PM, V5 checked the temperature of the water in the dish machine without the 3 compartment sink filled, and it was at 100 degrees Fahrenheit. V5 stated that they have not been using it this afternoon recently, but they would be sure to take the temperature before they wash anything to make sure it is hot enough. A policy titled Dietary Policies and Procedures Mechanical Ware Washing documents the dish machine should be used in accordance with the manufacturer's specifications 2. Record the parts per million (PPM), wash and rinse temperatures for the low temperature dish machine. 6. The logs should be completed before beginning to wash the breakfast, lunch and dinner dishes. The requirements for the machine must be met before washing/sanitizing the dishes. Follow the manufacturer's directions for checking temperature and sanitizer. Contact the chemical/machine company for any concerns. According to www.americandish.com, the manufacturer's guidelines for the American Dish Service dish machine used at the facility recommends a minimum of 120 degrees Fahrenheit for proper dish cleansing and sanitization. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. On 3/11/25 at 11:40 AM, V6 (Cook) was taking temperatures of foods in steam table to be served for lunch. V6 washed his hands, placed gloves on, opened a cabinet drawer to get a thermometer out, opened a drawer to get the serving utensils out, took off the covers to the food items on the steam table and with those same gloved hands while checking the temperature of the turkey, V6 picked up 3 slices of turkey and stated it sure feels hot. As the lunch service continued on, V6 used his same gloved hands to push foods off the serving spoon, and/or move the food around on the plate. V5 (Dietary Manager) stated at this time she would have a talk with V6 about not touching the food with his hands whether gloved or not. The facility's Proper Hand Washing and Glove Use policy documents: All employees will use proper hand washing procedures and glove usage in accordance with state and federal sanitation guidelines .7.Gloves are changed any time hand washing would be required. This includes when leaving the kitchen for a break, or to go to another location in the building; after handling potentially hazardous raw food; or if the gloves become contaminated by touching the face, hair, uniform, or other non-food contact surface, such as door handles and equipment. 8. Staff should be reminded that gloves become contaminated just as hands do, and should by changed often. When in doubt, remove gloves and wash hands again. The Long Term Care Facility Application for Medicare and Medicaid signed and dated 3/11/25, documents 40 residents residing in the facility.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49663 Based on observation and interview, the facility failed to safeguard medical record information against loss/destruction and ensure records were readily accessible for 3 (R2, R33, R38) of 3 residents reviewed in the sample of 27. The Findings Include: 1. R33's Electronic Health Record (EHR) included an Admission Record documenting R33 admitted to the facility on [DATE]. R33's EHR was missing records dated prior to 1/29/25 (such as progress notes, behavior tracking, physician orders, etc.). 2. R38's EHR included an Admission Record documenting R38 admitted to the facility on [DATE]. R38's EHR included an Minimum Data Set (MDS) assessment dated [DATE] documenting a discharge with return not anticipated assessment an listed a discharge status of Nursing Home (long-term care facility). R38's EHR was missing records dated prior to 1/29/25 (such as progress notes, physician orders, and a discharge summary, etc.). 3. R2's EHR included an Admission Record documenting R2 admitted to the facility on [DATE]. R2's EHR included an MDS assessment dated [DATE] documenting a discharge with return anticipated and listed a discharge status of Short-Term General Hospital. R2 had an MDS entry completed on 5/2/2024 to show R2 returned to the facility on this date. R2 had another MDS completed on 9/28/24 documenting a discharge with return anticipated assessment that listed a discharge status of Short-Term General Hospital with a subsequent entry completed on 10/3/2024 to show R2 returned to the facility on this date. R2's EHR was missing several records dated prior to 1/29/25 (such as progress notes, physician orders, and any records related to hospitalization s, etc.). On 3/13/2025 at 8:30 AM, in response to being asked to provide previous medical records for R2, R33 and R38, V13 (Medical Records) stated the medical records room had water damage related to a water pipe busting in the facility's sprinkler system. V13 stated half of the room holding residents' paper medical records dating prior to the facility's electronic health records going live on 1/29/25 are damaged and unreadable. On 3/13/2025 at 10:00 AM, V1 (Regional Director of Operations) stated the facility's electronic medical records went live on 1/29/25 but the facility did not have any way to obtain R2, R33 and R38's medical records dated prior to that date because of the medical records room flooding during a cold snap, leaving the paper documents illegible. On 3/13/2025 at 11:00 AM, surveyor requested documentation regarding R2's hospitalization s and V7 (Financial Coordinator) stated that she did not have any way to obtain R2's medical records for these dates due to the room where the medical records were kept flooded and all of the paper records are illegible. V7 clarified that the facility's electronic medical records went live on 1/29/25, so many of the paper records prior to that date were not available due to being destroyed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145664	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Axiom Healthcare of West Frankfort	601 North Columbia West Frankfort, IL 62896

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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 49663 Based on record review and interview, the facility failed to maintain documentation of holding quarterly Quality Assurance and Performance Improvement meetings (QAPI). This has the potential to affect all 40 residents residing in the facility. The Findings Include: During the investigation and review of facility records no evidence of quarterly QAPI meeting attendance or meeting information was found or produced by the facility. On 03/13/25 10:41 AM, V1 (Regional Director of Operations) stated the facility has been having quarterly QAPI meetings but she was unable to find any documentation of minutes or attendance sheets to show that the facility held quarterly QAPI meetings past 2/16/2024. The facility policy for Quality Assurance Performance Improvement Program with last revision date of 10/24/22 documents the following: Purpose: To ensure the organization has an organized quality assessment and improvement process program that includes performance measurement, performance assessment, and performance improvement and addresses the care and unique services provided by the facility. Guidelines: It is the policy of this facility to systematically improve its performance by having an organized Quality Assurance Performance Improvement Committee that assures a quality assessment and improvement program is planned, systematic, ongoing, and focused on those important processes or outcomes related to resident care and organizational functions. The committee functions and program shall be in accordance with the Quality Assessment and Improvement Standards of the Joint Commission on Accreditation of Healthcare Organizations for Long Term Care and federal and state regulations and in coordination with the overall Quality Assurance Performance Improvement program of this facility. Identification, Reporting, Investigation, Analysis & Prevention: The Committee shall identify issues with respect to quality assessment and assurance activities and assess results of specific quality assurance assessment reports during regularly scheduled meetings. Members assigned to attend per schedule shall present their reports in writing whenever possible and avoid the use of resident names or positive identifiers. The Committee will develop and implement appropriate plans of action and/or performance improvement plans to correct undesirable variations in performance. The status of identified problems or opportunities for improvement and action plans will be monitored by the committee to assure resolution. The Long Term Care Facility application for Medicare and Medicaid dated 3/11/25, documents 40 residents reside in the facility.