| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245475 | A. Building<br>B. Wing | 05/06/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Parkview Home | 102 County State Aid Highway 9<br>Belview, MN 56214 |

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 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>Based on interview and document review the facility failed to obtain a bed hold for 1 of 4 sampled residents (R24) reviewed for hospitalization Findings include: R24's 4/16/26, accepted discharge with return anticipated Minnimum Data Set (MDS) assessment identified R24 had an unplanned short-term general hospital stay beginning on 4/2/26. Additionally, the 4/6/26, accepted quarterly MDS assessment identified R24's cognition was intact. He was independent with set-up assistance from staff for Activities of Daily Living (ADLS), except dressing of lower body, which required some assistance from staff. He was able to ambulate independently and used no assistive devices. R24 had diagnoses including emphysema, heart disease with high blood pressure, congestive heart failure, diabetes, difficulty swallowing, and chronic kidney disease. R24's progress notes identified on 4/2/26 at 10:30 a.m. R24 was increasingly fatigued this morning and continued to be weak and was taken to the clinic by his family. At 3:06 p.m. facility received a phone call that R24 had been admitted to acute care for Pneumonia. On 4/3/26 a 3:29 p.m., R24 remained hospitalized and was discharged from the facility with a return anticipated. Interview on 5/5/26 at 12:51 p.m. with nursing consultant (NC)-A and the interim director of nursing (IDON) confirmed a bed hold should have been completed when the facility was notified R24 had been admitted to the hospital and there was no indication a bed hold had been completed either verbally or in writing. Review of the February 2024 Bed Hold Responsibilities policy identified all residents leaving the facility due to hospitalization or a therapeutic leave and chose to return were to complete a Bed Hold. The policy identified charges that would be incurred with a Bed Hold but failed to identify the process for completion of a bed hold. |

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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245475 | A. Building<br>B. Wing | 05/06/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Parkview Home | 102 County State Aid Highway 9<br>Belview, MN 56214 |

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 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>Based on interview and document review, the facility failed to revise the care plan for 2 of 12 sampled resident (R15 and R18) reviewed.Findings include: R15R15's 4/6/26, accepted quarterly Minimum Date Set (MDS) assessment identified R15's cognition was severely impaired. R15 was independent with her dressing, toileting and ambulation using a walker. R15 had occasional pain and took an antidepressant, diuretic, antiplatelet, and opioid medication. R15's current Diagnosis Report identified Alzheimer's disease, dementia, muscle weakness, long term use of pain medication, hallucinations, anxiety disorder, and high blood pressure. Observation and interview on 5/4/26 at 1:09 p.m., with R15 identified the facility took her scissors away from her and she cannot use her scissors anymore. She reported she was not endangering anyone, she had her knitting stuff but no scissors to cut the string. Observed was a bag next to her recliner with a large ball of yarn on the floor next to the bag with string from the ball of yarn draped into the bag. The bag was open at the top and other balls of yarn were inside the bag. She was unsure when the facility took her scissors. R15's 4/15/26, progress note identified housekeeping staff reported R15 had been cutting her clothes and R15 had cut her hair. Social service spoke to R15 about safety concern with scissors of cutting hair and cutting her clothing while on her. Plan will be to implement supervised scissor use and offer a hair appointment. The facility will provide time for staff and activity staff to utilize scissors when needed with yarn or other material items that are appropriate to cut. R15's undated, care plan identified self-directed leisure profile centered on her pastimes. Activities included that R15 enjoyed interactions with others and would continue with one-to-one interactions. R15 enjoyed music, being outside, going for walks, and putting together jigsaw puzzles. The facility staff were to respect R15's right to decline one-to-one interaction or other activities. There was no mention in the care plan that R15 would be offered supervised assistance with use of scissors for safety reasons. Interview on 5/5/26 at 9:34 a.m., with activity director (AD)-A identified she was unaware of any residents who needed supervision using some scissors. She reported that if a resident was identified to be unsafe using scissors the facility would ask the family to take the scissors home and set up a one-to-one with the resident to use the scissors in the activity room. Interview on 5/5/26 at 9:41 a.m., with interim director of nursing (IDON)-A identified she determined if someone was safe to use a scissors by looking at the residents cognitive level and any actions they may have taken. She would visit with the resident's family and try to allow the resident opportunities to continue to use a scissors with supervision if needed. She confirmed that R15 had been cutting her clothing and her hair with her scissors and was determined not to be safe with the scissors. R15 just needed to ask staff for her scissors and staff will assist or supervise her using her scissors. She confirmed that R15's care plan should reflect that she was unsafe to use her scissors unsupervised. R18R18's 5/6/26, accepted quarterly MDS assessment identified to have a Brief Interview for Mental Status (BIMS) score of 13, as cognitively intact. R18 was independent with dressing, toileting, and ambulation using his walker. R18 was noted to wander 1-3 days during the 7-day assessment period. R18 used oxygen, took antipsychotic, antidepressant, hypnotic, anticonvulsant, pain, and antiplatelet medication. R18's current Diagnosis Report identified stroke, one sided weakness, emphysema, chronic obstructive pulmonary disease (COPD), high blood pressure, muscle weakness, insomnia, major depression disorder, and a history of falling. Interview on 5/4/26 at 2:00 p.m., with R18 identified he had an alarm on, and he wanted to go outside but could not. He reported this was illegal and he was calling the police and telling the state people and was waiting to see what they did (the facility). He said this must be against the law to have this thing on so he could not go outside. R18 then reported staff told him he needed someone to go outside with him but remarked there was never anyone that had time. When asked about going out into the enclosed courtyard, he reported he could go out there, but he did not want to. He wanted to sit out front and look around. R18's current, care plan identified R18 had<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245475 | A. Building<br>B. Wing | 05/06/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Parkview Home | 102 County State Aid Highway 9<br>Belview, MN 56214 |

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 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | cognition focus related to diagnosis of dementia and cognitive deficits as evidenced by BIMS. Staff were to communicate with R18 and address his needs and support his capabilities. Staff were to cue, reorient and supervise as needed, monitor cognitive function and report changes. Staff were to provide information and allow R18 to make decisions independently. R18 had a wander guard based on elopement assessment. The care plan lacked identification that R18 was at risk for elopement and what the goal was. There were no interventions of what staff were to do if R18 attempted to leave, or interventions to help meet R18 needs when he wanted to go outside and sit or take a walk. R18's 3/24/26 elopement evaluation identified he wanted to return home and was one time progress notes at 6:41 p.m., identified R18 had gone outside, staff observed R18 and went outside with him. R18 had said he was leaving and wanted to go home. Staff had walked with R18 to the assisted living apartment entrance. R18 entered the assisted living and began visiting with the staff at the assisted living. The assisted living staff assisted R18 later to the long-term care side of the building. A wander guard will be started. R18's 4/16/26, Elopement Evaluation identified R18 did not have a history of elopement or an attempted elopement while at home. R18 did not express the desire to go home and/or pack his belongings to go home or stay by an exit door. R18 did not wander and had not been admitted recently within the last 30 days. The risk for wandering and/or elopement was left blank with no care plan focus, goal, or interventions identified. The assessment did not identify the prior history of elopement or attempts to leave the facility without informing staff or R18's desire to go home. Interview on 5/5/26 at 1:14 p.m., with activity director (AD)-A identified she assessed residents' likes and dislikes and reviewed things they enjoyed prior to coming to the facility. For residents who have a wander guard on, and they want to go outside she would attempt to take them out depending on the weather and staff availability. Interview on 5/5/26 at 1:24 p.m., with nursing assistant (NA)-A identified R18 liked to go outside and sit in front of the building. The activity staff did take him outside when they can. R18 did go to the doors and attempt to go out on his own, but he has a wander guard on, so the door alarmed when he did that. R18 did make comments about not being able to go outside by himself. If someone cannot take him out front, we remind R18 he can go out in the courtyard by himself if he wants too. Interview on 5/5/26 at 2:58 p.m., with registered nurse consultant (RNC)-A identified R18 went out of the building but did not leave the premises so according to the facility policy that was not considered an elopement. She confirmed an elopement assessment had been completed on 3/24/26 and a wander guard had been applied to R18. When NC-A was asked if the care plan should have been revised to identify R18 was at risk for elopement with interventions of what staff were to do when he attempted to go outside, she stated I will not answer that. She then reported that the floor nurses do not update care plans as they have not been educated on updating care plans and at this time only NC-B and the interim director of nursing (IDON) updated care plans. Interview on 5/5/26 at 3:10 p.m., with RNC-B identified R18's care plan met the minimum requirements as RNC-B had put on R18's care plan that he had a wander guard per his elopement assessment. RNC-B agreed that the care plan could be more detailed and have identified interventions of what staff were to do if R18 was wanting to leave. Interview on 5/6/26 at 8:38 a.m., with licensed practical nurse (LPN)-B identified R18 asked to go outside all the time. R18 had moved from the attached assisted living to the nursing home a couple months ago. At that time while he was living in assisted living, he was free to walk around outside but he had declined, and it was just not safe for him to do that anymore. The ground was uneven, and she was not sure if he walked away from the facility, he would be able to find his way back. R18's cognition varies day by day, so it is hard for R18 to wait for someone to go outside with him. The staff try to take him outside when they can. Review of undated, Care Plan Revisions Upon Status Change policy identified when a resident experiences a change the facility will discuss the change and collaborate on intervention options. The team meeting would be documented in the resident medical record, and the care plan would be updated to reflect the change and new interventions. The nurse manager or designated staff member would communicate the changes to all staff involved with the resident's care. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245475 | A. Building<br>B. Wing | 05/06/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Parkview Home | 102 County State Aid Highway 9<br>Belview, MN 56214 |

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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on observation, interview, and document review, the facility failed to ensure staff had appropriately followed medication administration through to completion for 1 of 1 sampled resident (R4) with a nebulized (inhaled) medication by providing appropriate supervision and follow policy and procedure for the cleaning of the medication cup after administration was completed. Findings include: R4's quarterly Minimum Data Set (MDS) assessment accepted on 4/6/26, identified her cognition was intact and had diagnoses of chronic obstructive pulmonary disease (COPD), respiratory failure with hypoxia (low oxygen levels), and was dependent on supplemental oxygen, sleep apnea. R4 required moderate assistance of 1 staff for transfers, dressing, and hygiene. Observation on 5/4/26 at 5:30 p.m., in R4's room identified a handheld nebulizer was lying on her end table still connected to the nebulizer machine. The cup that holds the liquid medication still contained approximately half of the liquid medication. R4 was not in the room. Observation and interview on 5/4/26 at 5:45 p.m., with registered nurse (RN)-A identified she observed the nebulizer cup on the end table. She agreed there was a moderate amount of medication remaining in the cup. She identified nursing should have followed up with R4 to ensure the medication had been fully administered. In addition, she said the handheld nebulizer should have been disassembled and rinsed following the completion of the administration to prevent potential infection. She further identified the nebulizer treatment was scheduled to be administered at 2:00 p.m., confirming this treatment had occurred 3 hours and 45 minutes prior to this observation. R4's May 2026 medication administration record (MAR) identified on 5/4/26 documentation that R4 had received a nebulizer treatment of ipratropium/albuterol inhalation solution 0.5-2.5 milligrams (MG) per milliliter (ML) for acute respiratory failure with hypoxia at 2:00 p.m The documentation identified RN-B had signed off the completion of the nebulizer treatment. The MAR further identified R4 was able to self-administer oral medications and nebulizers after set- up. Observation on 5/5/26 at 8:34 a.m., of R4's room identified her hand-held nebulizer was again laying on her end table assembled with approximately 1/4th of the liquid medication remaining in the cup. R4 was lying in bed asleep. Interview on 5/5/26 at 8:37 a.m., with licensed practical nurse (LPN)-A identified R4 had not been administered any medication for morning medication pass. She confirmed the nebulizer was still lying on the end table and had a small amount of medication still in the cup. She reviewed the medication record and identified the last nebulizer treatment had been during the night at 1:20 a.m. R4's 4/13/26, self-administration of medication assessment, completed by RN Consultant (RNC-B), identified R4 was not capable of self-administering inhalants or use inhalers without supervision. The summary identified R4 was not safe to self-administer at that time. Interview on 5/5/26 at 12:35 p.m., with RNC-B identified he had completed the assessment when R4 returned following a hospital stay on 4/13/26. He identified the assessment was accurate and agreed he did not update R4's administration record to show she was no longer safe to self-administer nebulizer treatments. He agreed he should have updated the MAR immediately to ensure nursing staff were aware they would need to supervise R4 while she completed her nebulizer treatments. Interview on 5/5/26, at 1:00 p.m., with the interim director of nursing (IDON) identified it was her expectation that staff follow the facility policy for nebulizer treatments. She further identified they have noted in the orders if a resident is safe to self-administer and that all areas of the electronic medical record should have been updated immediately following the change with re-assessment. Review of the undated facility Nebulizer Therapy Policy identified staff were to verify the order, assemble the tubing and nebulizer cup, place the ordered medication solution into the nebulizer cup, remain with the resident during the procedure and monitor for any change in condition. When the medication is complete, staff were to disassemble, rinse the nebulizer with warm water and allow to air-dry. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245475 | A. Building<br>B. Wing | 05/06/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Parkview Home | 102 County State Aid Highway 9<br>Belview, MN 56214 |

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 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>Based on observation, interview and document review, the facility failed to ensure documentation of 1 of 1 sampled resident's (R4) ability to self-administer medication was consistent and accurate throughout the medical record.Findings include: R4's quarterly Minimum Data Set (MDS) assessment accepted on 4/6/26, identified her cognition was intact, she had diagnoses of heart failure, chronic obstructive pulmonary disease (COPD), respiratory failure with hypoxia, dependence on supplemental oxygen, sleep apnea, and atrial fibrillation. R4 requires moderate assistance of 1 staff for transfers, dressing, and hygiene. Observation on 5/4/26 at 5:30 p.m., in R4's room identified a handheld nebulizer was lying on her end table still connected to the nebulizer machine. The cup that holds the liquid medication still contained approximately half of the medication. R4 was not in the room. R4's May 2026 medication administration record (MAR) identified on 5/4/26 staff documented that R4 had received a nebulizer treatment of ipratropium/albuterol inhalation solution 0.5-2.5 milligrams (MG) per milliliter (ML) for acute respiratory failure with hypoxia at 2:00 p.m., the documentation identified RN-B had signed off the completion of the nebulizer treatment. The MAR further identified R4 was able to self-administer oral medications and nebulizers after set- up. R4's 4/13/26, self-administration of medication assessment, completed by RN Consultant (RNC-B), identified R4 was not capable of self-administering inhalants or use inhalers without supervision. The summary identified R4 was not safe to self-administer at that time. Interview on 5/5/26 at 12:35 p.m., with RNC-B identified he had completed the assessment when R4 returned following a hospital stay on 4/13/26. He identified the assessment was accurate and agreed he did not update R4's administration record to show she was no longer safe to self-administer nebulizer treatments. He agreed he should have updated the MAR immediately to ensure nursing staff were aware they would need to supervise R4 while she completed her nebulizer treatments. Interview on 5/5/26, at 1:00 p.m., with the interim director of nursing (IDON) identified it was her expectation that staff follow the facility policy for nebulizer treatments. She further identified they have it noted in the orders on the MAR if a resident is safe to self-administer and that should have been updated immediately following the change with re-assessment. Review of the undated facility Resident Self-Administration of Medication policy identified the interdisciplinary team (IDT) would complete the assessment to determine if the resident was clinically appropriate to self-administer medications. The results of the IDT assessment were to be recorded on the Medication Self-Administration Assessment form and added to the resident's medical record. The policy made no mention that staff were to update/revise the MAR to reflect the results of the assessment. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245475 | A. Building<br>B. Wing | 05/06/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Parkview Home | 102 County State Aid Highway 9<br>Belview, MN 56214 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observation, interview, and document review the facility failed to ensure 1 of 1 observed nebulizer (inhaled medication) medication cup was rinsed and left to air dry after each medication administration for 1 of 1 resident (R4) to prevent potential complication of infection. Findings include: R4's quarterly Minimum Data Set (MDS) assessment accepted on 4/6/26, identified her cognition was intact, she had diagnoses of heart failure, chronic obstructive pulmonary disease (COPD), respiratory failure with hypoxia, dependence on supplemental oxygen, sleep apnea, and atrial fibrillation. R4 requires moderate assistance of 1 staff for transfers, dressing, and hygiene. Observation on 5/4/26 at 5:30 p.m., in R4's room identified a handheld nebulizer was lying on her end table still connected to the nebulizer machine. The cup that holds the liquid medication still contained a approximately half of the medication. R4 was not in the room. Observation and interview on 5/4/26 at 5:45 p.m., with registered nurse (RN)-A observed the nebulizer cup on the end table. She agreed there was a moderate amount of medication remaining in the cup. She identified nursing should have followed up with R4 to ensure the medication had been fully administered, in addition she said the handheld nebulizer should have been disassembled and rinsed following the completion of the administration. She further identified the nebulizer treatment was scheduled to be administered at 2:00 p.m., confirming this treatment had occurred 3 hours and 45 minutes prior to this observation. R4's May 2026 medication administration record (MAR) identified on 5/4/26 staff documented that R4 had received a nebulizer treatment of ipratropium/albuterol inhalation solution 0.5-2.5 milligrams (MG) per milliliter (ML) for acute respiratory failure with hypoxia at 2:00 p.m. The documentation identified RN-B had signed off the completion of the nebulizer treatment. The MAR further identified R4 was able to self-administer oral medications and nebulizers after set- up. Observation on 5/5/26 at 8:34 a.m., of R4's room identified her hand-held nebulizer was again laying on her end table assembled with approximately 1/4th of the liquid medication remaining in the cup. R4 was lying in bed asleep. Interview on 5/5/26 at 8:37 a.m., with licensed practical nurse (LPN)-A identified R4 had not been administered any medication yet that morning. She confirmed the nebulizer was still lying on the end table and had a small amount of medication still in the cup. She reviewed the medication record and identified the last nebulizer treatment had been during the night at 1:20 a.m. R4's 4/13/26, self-administration of medication assessment, completed by RN Consultant (RNC-B), identified R4 was not capable of self-administering inhalants or use inhalers without supervision. The summary identified R4 was not safe to self-administer at that time. Interview on 5/5/26, at 1:00 p.m., with the interim director of nursing (IDON) identified it was her expectation that staff follow the facility policy for nebulizer treatments. She further identified she would expect staff to remain with the resident to ensure the entire dose of the medication was administered. She would expect it to be noted in the orders if a resident is safe to self-administer and that should have been updated immediately following the change with re-assessment. Review of the undated facility Nebulizer Therapy Policy identified staff were to verify the order, assemble the tubing and nebulizer cup, place the ordered medication solution into the nebulizer cup, remain with the resident during the procedure and monitor for any change in condition. When the medication is complete, staff were to disassemble, rinse the nebulizer with warm water and allow to air-dry. |