| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265591 | A. Building<br>B. Wing | 03/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Parkdale Manor Health & Rehabilitation | 814 West South Avenue<br>Maryville, MO 64468 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0582<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.<br><br>18750<br><br>Based on interview, record review, and policy review, the facility failed to ensure residents were provided the Skilled Nursing Facility Advance Beneficiary Notice, form CMS-10055, or the Notice of Medicare Non-coverage (NOMNC) form CMS-10123 for Medicare Part A Services when they were no longer covered or coverage was ending for two of three residents reviewed (Resident (R) 24, and R32) out of a total sample of 18 residents. This deficient practice had the potential for residents not to be provided the information about what services may not be covered by Medicare for residents to make an informed decision about receiving therapies.The facility census is 28.<br><br>Review of the facility policy titled, Medicare Advance Beneficiary Notices dated April 2021 revealed, Policy Statement: Residents are informed in advance when changes will occur to their bills. Policy Interpretation and Implementation<br><br>1. If the director of admissions or benefits coordinator believes (upon admission or during the resident's stay) that Medicare (Part A of the Fee for Service Medicare Program) will not pay for an otherwise covered skilled service(s), the resident (or representative) is notified in writing why the service(s) may not be covered and of the resident's potential liability for payment of the non-covered service(s). a. The facility issues the Skilled Nursing Facility Advanced Beneficiary Notice (CMS form 10055) to the resident prior to providing care that Medicare usually covers but may not pay for because the care is considered not medically reasonable and necessary, or custodial.<br><br>b. The resident (or representative) may choose to continue receiving the skilled services that may not be covered and assume financial responsibility.<br><br>2. If the resident's Medicare Part A benefits are terminating for coverage reasons, the director of admissions or benefits coordinator issues the Notice of Medicare Non-Coverage (CMS form 10123) to the resident at least two calendar days before Medicare covered services end (for coverage reasons). a. The Notice of Medicare Non-Coverage informs the resident of the pending termination of coverage and of his/her right to an expedited review of service determination.<br><br>b. The Notice of Medicare Non-Coverage is not indicated when the resident's Medicare covered days are exhausted; nor is it used to notify the resident of potential liability for payment.<br><br>(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 0582<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 1. Review of an undated document titled, SNF Beneficiary Notification Review for R24 indicated, .Medicare Part A Skilled Services Episode State date was: 10/06/24. The last covered day of Part A Services was 12/18/24. The form indicated, The facility-provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted. Further review of the document indicated, Was an SNF/ABN, Form (CMS-10055) provided to the resident? It was marked, No. If no, explain why the form was not provided: The box Other was marked and the explanation was written Oversight.<br><br>Review of R24's electronic medical record (EMR) revealed no documentation that communication took place between R24 and/or the representative to discuss potential additional costs that the resident might have to pay if they chose to continue to receive services.<br><br>2. Review of an undated document titled, SNF Beneficiary Notification Review for R32 indicated, .Medicare Part A Skilled Services Episode State date was: 01/21/25. The last covered day of Part A Services was 01/27/25. The form indicated, Voluntary, i.e., self-initiated in consultation with physician, family, or AMA. Further review of the document indicated, Was an NOMNC, Form (CMS-10123) provided to the resident? It was marked, No. If no, explain why the form was not provided: The box Other was marked and the explanation was written Oversight.<br><br>Review of R32's EMR revealed no documentation that communication took place between R32 and/or the representative to discuss potential additional costs that the resident might have to pay if they chose to continue to receive services.<br><br>During an interview on 03/14/25 at 9:24 AM, the Administrator stated the SNF ABN should have been provided for R24, and it was an oversight. The NOMNC was provided for R32, but it could not be located.<br><br>During an interview on 03/14/25 at 10:14 AM, Social Services (SS) was asked about the forms not being provided to the residents. The SS stated she was not aware that the form had to be provided for R24. The SS was asked about the forms for R32 and the SS stated, They were completed, I can't locate them. |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18750<br><br>Based on record review and interview, the facility failed to initiate a new PASARR (Pre-Admission Screening and Resident Review) Level One for one of four residents (Resident (R) 21) reviewed for PASARR to reflect new psychiatric diagnoses out of a total sample of 18 residents. The failure to maintain a PASARR Level One that reflected the new diagnoses of R21 had the potential to delay or limit necessary assistance should R21 experience a psychiatric episode that disrupted her daily life. The facility census is 28.<br><br>Review of the Census tab in the electronic medical record (EMR) revealed R21 was originally admitted on [DATE].<br><br>Review of the Level One Nursing Facility Pre-Admission Screening for Mental Illness, Intellectual Disability, or Related Condition signed by the hospitalist on 11/30/21 prior to R21's admission to the facility and provided by the Administrator revealed the screening form contained the demographics fields to be complete, but the medical/psychiatric questions were unanswered, and the fields were blank. The pre-admission screening did not indicate whether the result was positive or negative for the need of a PASRR Level Two.<br><br>Review of the Med Diag [Medical Diagnoses] tab of the EMR revealed R21 was diagnosed with major depressive disorder on 10/20/22 and bipolar two disorder on 02/07/23.<br><br>Review of the Orders tab in the EMR revealed divalproex (anticonvulsant used for manic phase of depressive disorder) 125mg capsule twice a day related to major depressive disorder initiated on 10/18/22 and Cymbalta (antidepressant) 60mg capsules once daily related to major depressive disorder initiated on 12/11/22.<br><br>Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/03/23 under the MDS tab in the EMR revealed R21 had depression (other than bipolar) and bipolar disorder indicated as current diagnoses.<br><br>Review of the Misc (Miscellaneous) tab in the EMR revealed several psychiatric notes related to R21's diagnoses and behaviors.<br><br>In an interview on 03/14/25 at 9:20 AM, the Social Services (SSD) staff verified that there was no updated PASRR Level One to reflect R21's current diagnoses of major depressive disorder or bipolar II disorder. She confirmed a new screening should have been completed with each new diagnosis.<br><br>A PASRR policy was requested for from the Administrator and SSD staff; no policy was provided. |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18750<br><br>Based on record review, interview, and policy review, the facility failed to provide a PASARR<br><br>(Pre-Admission Screening and Resident Review) Level One for one of four residents (Resident (R)21) reviewed for PASARR to reflect a positive or negative screen result out of 18 sample residents. The failure to maintain a PASARR Level One that reflected either a positive or negative screen result had the potential to limit or delay the assistance needed for R21 should R21 experience a psychiatric episode. The facility census is 28.<br><br>Review of the Census tab in the electronic medical record (EMR) revealed R21 was originally admitted on [DATE].<br><br>Review of the Med Diag (Medical Diagnoses) tab of the EMR revealed that R21 was diagnosed with morbid obesity and dysphagia. There was no reference to a psychiatric diagnosis.<br><br>Review of the Level One Nursing Facility Pre-Admission Screening for Mental Illness, Intellectual Disability, or Related Condition signed by the hospitalist on 11/30/21 prior to R21's admission to the facility on [DATE] and provided by the Administrator revealed the screening form contained the demographics fields to be complete, but the medical/psychiatric questions were unanswered, and the fields were blank. The pre-admission screening did not indicate whether the result was positive or negative for the need for a PASRR Level Two.<br><br>In an interview on 03/14/25 at 9:20 AM the Social Services (SSD) staff, verified the provided PASRR form from 11/30/21 did not show any psychiatric questions answered nor did the form state if the PASRR screen produced a positive or negative result. The SSD staff stated the point tally indicated on the first page is used for purposes of determining if the person can be admitted to a nursing facility. The SSD staff confirmed the PASRR Level One in R21's chart was incomplete.<br><br>Review of the facility policy Admission Criteria revised March 2019 provided by the Administrator revealed, all new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID), or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) Process. |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18750<br><br>Based on interview, record review, and policy review, the facility failed to ensure showers were provided per resident preference for one of 18 sampled residents (Resident (R)18). This deficient practice had the potential for residents dependent on staff to not maintain personal hygiene and not maintain participation in activities of daily living. The facility census is 28.<br><br>Review of the facility policy titled, Activities of Daily Living (ADLs), Supporting revised March 2018, revealed, Policy Statement: Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Policy Interpretation and Implementation I. Residents will be provided with care, treatment, and services to ensure that their activities of daily living (ADLs) do not diminish.<br><br>2. Appropriate care and services will be provided for residents who are unable to carry out ADLs<br><br>independently, with the consent of the resident and in accordance with the plan of care, including<br><br>appropriate support and assistance with a. hygiene (bathing, dressing, grooming, and oral care) .<br><br>Review of R18's Admission Record located in the electronic medical record (EMR) under the Profile tab indicated R18 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses of cerebral infarction (stroke) due to embolism of right middle cerebral artery, hemiplegia and hemiparesis of left non-dominant side, and major depression.<br><br>Review of R18's EMR revealed a quarterly Minimum Data Set (MDS) assessment located under the MDS tab with an Assessment Reference Date (ARD) of 12/13/24 revealed a Basic Interview for Mental Status (BIMS) score of 15 out of 15 indicating intact cognition. ADLs were assessed as maximal assistance of two staff.<br><br>Review of the R18's EMR revealed a revised care plan dated 07/20/23, located under the Care Plan tab that indicated R18 had limited physical mobility and preferred showers.<br><br>Review of the Daily Shower Schedule updated 02/14/25 located at the nurse's station revealed R18 was scheduled for showers on Tuesdays, Thursdays, and Saturdays.<br><br>During an interview on 03/11/25 at 1:33 PM, R18 stated he wanted showers three times a week and he had not showered in the last six days. When asked why he had not showered, he stated he did not know.<br><br>Review of R18's showers sheet provided by the facility revealed in February 2025 no showers were provided on 02/11/25, 02/13/25 and 02/15 25. Review of March 2025 revealed no showers were provided on 03/06/25 and 03/08/25. The facility census is 28<br><br>(continued on next page) |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 03/12/25 at 2:03 PM, Certified Nursing Aide (CNA) 2 was asked about R18's showers. CNA 2 stated there was a list of when residents received their showers and R18 received them on Tuesday, Thursdays, and Saturdays. CNA 2 was asked how showers were assigned to staff. CNA2 stated usually someone will volunteer to give the showers and the rest of the staff will provide cares and answer lights so there is no set assignment.<br><br>During an interview on 03/13/25 at 10:06 AM, Registered Nurse (RN)1 was asked about the showers. RN1 stated that a CNA is assigned to the showers and if a resident refuses then the CNA comes and tells the nurse and then the nurse is to talk with the resident and if the shower is still refused chart it. RN 1 was asked if there was documentation that R18 refused. RN 1 stated no. RN1 was asked how she follows up with staff to ensure showers are provided. RN 1 did not answer.<br><br>During an interview on 03/14/25 at 9:27 AM, the Director of Nursing (DON) was asked about R18 not receiving showers. The DON stated R18 had told her that he had not received a shower in 6 days. The DON stated, I gave him a shower. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18750<br><br>Based on the policy review, record review, and interview, the facility failed to follow the recommendations to obtain weekly weights for one of two residents (Resident (R) 27) reviewed for nutrition out of a total sample of 18 resident which caused inadequate tracking of weight loss or gain. The facility census is 28.<br><br>Review of the facility's policy titled Weighing and Measuring revised March 2011 revealed .The purpose of this procedure are to determine the resident's weight and height, to provide a baseline and an ongoing record of the resident's body weight as an indicator of the nutritional status and medical condition of the resident, and provide a baseline height in order to determine the ideal weight of the resident .<br><br>Review of the Face Sheet located in the Profile tab in the electronic medical record (EMR) revealed R27 was admitted to the facility on [DATE] with diagnoses which included acute and chronic respiratory failure and moderate protein-calorie malnutrition.<br><br>Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date dated 02/27/25 revealed R27 had a Brief Interview for Mental Status (BIMS) score of 99 indicating R27 could not participate in the assessment. R27 was totally dependent on enteral feeding (tube feeding) from the nurses.<br><br>Review of R27's Physician orders located in the Orders tab dated 08/15/24 revealed .NPO [nothing by mouth] diet .<br><br>Review of the Request for Diet Changes dated 11/06/24 revealed .1. Monitor weekly wts [weights] .<br><br>Review of R27's Physician orders located in the Orders tab dated 01/07/25 revealed .Monitor Weekly Weights .<br><br>Review of the Request for Diet Changes dated 01/08/25 revealed .1. Obtain January wt. 2. Monitor weekly weights . Most recent weight in PCC [EMR] 8/24 .<br><br>Review of the Request for Diet Changes dated 02/10/25 revealed .1. Obtain February weight .<br><br>Review of the R27's weights found located in the vitals tab dated 08/16/24 150 lbs. (pounds), 01/15/25 162 lbs., 02/11/25 163.6 lbs., 02/20/25 160. 2 lbs., 03/10/25 162.4 lbs. which indicated a weight gain.<br><br>Review R27's care plan found in the care plan tab in the EMR dated 02/10/25 revealed R27 was care planned to be NPO except mouth care. Interventions were to weigh R27 monthly and as ordered by the provider and to note any significant changes in R27's weight and to notify the provider.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a telephone interview on 03/13/25 at 12:38 PM, the Registered Dietician (RD) stated the nursing department oversaw making sure the weights were being completed. The RD made a request for the nursing department to monitor weekly weights indefinitely. The RD made this recommendation March 6, 2025, January 8, 2025, December 4, 2024, and November 6, 2024. The RD stated that she writes her recommendations and gives them the Director of Nursing (DON), Dietary Manager, and Administrator and expected the recommendations to be implemented within two weeks. The RD used the admission weight to make sure R27 was getting the correct calories and protein. When there was no weight in the EMR the RD asked the nursing department to obtain weights. The RD stated R27 weights should be obtained weekly.<br><br>During an interview on 03/13/25 at 12:59 PM, the DON stated the Restorative Aide was responsible for obtaining all the residents' weights. The nurses were responsible for making sure weights were obtained as ordered. The DON stated the lift which was used to weigh R27 was broken, and she was just made aware of it. The DON did not know how long the lift had been broken.<br><br>During an interview on 03/13/25 at 1:11 PM, the Restorative Aide stated she was responsible for obtaining weights for all residents The Restorative Aide stated she was not told R27 was supposed to be on weekly weights.<br><br>During an interview on 03/13/25 at 1:23 PM, the Registered Nurse (RN)1 stated whoever was the charge nurse made sure the residents' weights were completed and added to the EMR.<br><br>During a telephone interview on 03/14/25 at 1:06 PM, the Medical Director stated she did not remember whether she saw the recommendations or not but would have done whatever the Registered Dietician recommended. The RD usually left a form, and the Medical Director would sign off on it. Further interview revealed the Medical Director was not aware the lift used to weigh R27 was not working. The Medical Director stated, If I sign an order, I expect them (nursing staff) to follow the order to weigh the patient.<br><br>During an interview on 03/14/25 at 1:45 PM, the Administrator stated she did not know there was an issue with the facility getting consistent weights for R27. The Administrator noticed in her report the RD had made recommendations regarding R27 weights. The Administrator's expectations were that if the RD made recommendations, it should be sent to the primary care physicians. The Administrator was made aware of the lift was not working. |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18750<br><br>Based on policy review, record review, observations, and interviews, the facility failed to label and date enteral feedings for two of two residents (Residents (R) 27 and R29) who required enteral feedings out of a total sample of 18 residents. This failure increased the risk of nurses not knowing if the correct formula and rate was being provided and what date the formula was hung. The facility census is 28.<br><br>Review of the policy titled Enteral Feeding via Continuous Pump revised November 2018 revealed . On the formula label document initials, date and time the formula was hung/administered, and initial that the label was checked against the order .<br><br>1.Review of R27's Face Sheet located in the Profile tab in the electronic medical record (EMR) revealed R27 was admitted to the facility on [DATE] with diagnoses which included acute and chronic respiratory failure and moderate protein-calorie malnutrition.<br><br>Review of R27's Physician orders located in the Order tab in the EMR dated 08/15/24, revealed .NPO [nothing by mouth] diet .<br><br>Review of R27's Physician orders located in the Order tab dated 12/11/24, revealed enteral feed every day and night shift for enternal feed of Jevity (protein and calorie liquid food) 1.5 at 65 ml (milliliter)/hour. Enteral feeding is provided through a tube that is surgically inserted through the abdomen into the stomach.<br><br>Review of R27's care plan located in the Care Plan tab in the EMR dated 01/13/25, revealed R27 required tube feeding of Jevity 1.5.<br><br>Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/27/25, revealed R27 had a Brief Interview for Mental Status (BIMS) score of 99 indicating R27 could not participate in the assessment. R27 was totally dependent on enteral feeding from the nurses.<br><br>Observation in R27's room on 03/11/25 at 11:04 AM, revealed the enteral feeding bag had formula and was running. The bag was unlabeled without the type of formula, the rate to run, the time it was hung, and which nurse hung the formula.<br><br>Observation and interview in R27's room on 03/11/25 at 3:04 PM, revealed the enteral feeding bag had formula and was running. The bag was unlabeled without the type of formula, the rate to run, the time it was hung, and which nurse hung the formula. Licensed Practical Nurse (LPN) 4 confirmed R27's enteral feeding bag was not labeled. LPN 4 stated the night nurse were the ones to hang the bag and usually wrote the name of the formula, date time it was hung, and initials of who hung it.<br><br>2.Review of R29's Face Sheet located in the Profile tab in the electronic medical record (EMR) revealed R29 admitted to the facility on [DATE], with diagnoses which included gastrostomy (tube surgically placed through the abdomen and into the stomach for fluids, nutrition, and medications) status and dysphagia.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of R29's physician orders located in the Orders tab and dated 03/07/25, revealed an enteral feed order every shift Jevity 1.5 at 45 ml continuous.<br><br>Review of R29's care plan located in the Care Pla tab in the EMR dated 02/12/25, revealed .The resident has dehydration or potential fluid deficit r/t [related to] being NPO and receiving all nutrition enterally through J-tube. [named R29] also has a G-tube for gastric draining .<br><br>Review of R29's admission MDS with an ARD of dated 02/17/25, revealed R29 had a BIMS score of 99 indicating R29 could not participate in the assessment. R29 was totally dependent on enteral feeding from the nurses.<br><br>Observation in R29's room on 03/11/25 at 11:22 AM, revealed R29's enteral feeding bag had formula and was running. The bag was unlabeled without the type of formula, the rate to run, the time it was hung, and which nurse hung the formula.<br><br>Observation and interview in R27's room on 03/11/25 at 3:01 PM, revealed the enteral feeding bag had formula and was running. The bag was unlabeled without the type of formula, the rate to run, the time it was hung, and which nurse hung the formula. LPN 4 confirmed R27's enteral feeding bag was not labeled. LPN 4 confirmed the nurses were supposed to label the enteral feeding bags with the date, time, name of formula, and who hung it.<br><br>During an interview on 03/14/25 at 1:55 PM, the Director of Nursing stated the night nurses were responsible for hanging the enteral feeding for R27 and R29 and labeling the bags. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265591 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/14/2025 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Parkdale Manor Health & Rehabilitation | 814 West South Avenue<br>Maryville, MO 64468 |

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

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>18750<br><br>Based on observation, interview, record review, and policy review, the facility failed to ensure the oxygen (O2) concentrators had dust free filters on the inlet where the air came into the machine for one of two residents (Resident (R) 25) reviewed for oxygen usage out of a total sample of 18 residents. This deficient practice had the potential for increased chance of infection and unnecessary respiratory treatment. The facility census is 28.<br><br>Review of the facility's policy titled, Departmental (Respiratory Therapy)- Prevention of Infection revised November 2011, revealed, Purpose: The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff. Steps in the Procedure Infection control considerations Related to oxygen Administration. 9.Wash filters from oxygen concentrators every seven days with soap and water. Rinse and squeeze dry.<br><br>1. Review of R25's undated Face Sheet located in R25's electronic medical record (EMR) under the Profile tab, indicated diagnoses to include solitary pulmonary nodule, chronic respiratory failure with hypercapnia (increased carbon dioxide), and asthma.<br><br>Review of Physician Orders, dated 01/07/25 and located in R25's EMR under the Orders tab, indicated Oxygen 3LPM [liters per minute] via nasal cannula continuously.<br><br>During an observation on 03/11/25 at 10:16 AM, R25's oxygen concentrator located in R25's room and was observed to have a black oxygen filter on both sides of the concentrator. Both filters were observed to be full of a buildup of a large amount of white lint and heavy debris and were observed to be very dirty.<br><br>During an observation on 03/12/25 AM, R25's oxygen concentrator filters were observed to be full of a large buildup of white lint and heavy debris and were observed to be very dirty<br><br>During observation and interview on 03/13/25 at 9:45 AM, Registered Nurse (RN)1 was shown the filters. RN1 stated no the filters should not look like this. The RN added it should be everyone's responsibility to look at them, but ultimately the nurse was responsible.<br><br>During an observation and interview on 03/13/25 at 10:25 AM, the Director of Nursing (DON) was shown the filters. The DON stated, They are not clean. The DON was asked who should be cleaning them. The DON stated the night nurse on Sunday nights should be cleaning them weekly. |

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| F 0865<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a plan that describes the process for conducting QAPI and QAA activities.<br><br>18750<br><br>Based on interview and policy review, the facility failed to ensure a Quality Assurance and Performance Improvement (QAPI) program to identify, maintain, and evaluate concerns for effective resident care. This deficient practice had the potential to not identify issues and/or capture the efforts made in measuring the care and services for 28 residents.The facility census is 28.<br><br>Review of the facility policy titled Quality Assurance and Performance Improvement (QAPI) Program revised April 2014 revealed, Policy Statement The facility shall develop, implement, and maintain an ongoing, facility-wide Quality Assurance and performance Improvement (QAPI) program to actively pursue quality of care and quality of life goals.<br><br>During an interview on 03/14/25 at 12:12 PM, the Administrator was asked about the QAPI Program, and an example of a Performance Improvement Projects (PIP) that was in progress. The Administrator stated they were not currently working on a PIP due to not having the staffing in place to perform QAPI activity. The Administrator was asked how the facility identified issues and worked on improvements. The Administrator stated there were several different meetings such as risk, infection control or clinical in which topics were discussed and reviewed but there had not been the staff for QAPI. |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.<br><br>18750<br><br>Based on interview and policy review, the facility failed to ensure a Quality Assurance and Performance Improvement (QAPI) program committee met on a quarterly basis to work on performance improvement projects (PIP) and track the performance of the PIP. This deficient practice had the potential to not identify or improve the care and services for 28 residents.The facility census is 28.<br><br>Review of the facility policy titled, Quality Assurance and Performance Improvement (QAPI) Plan revised April 2014 revealed, Policy Statement This facility shall develop, implement, and maintain an ongoing, facility-wide QAPI Plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve care quality, and resolve identified problems.<br><br>Policy Interpretation and Implementation<br><br>The objectives of the QAPI Plan are to:<br><br>1. provide a means to identify and resolve present and potential negative outcomes related to resident care and services;<br><br>2. Provide structure and processes to correct identified quarterly and/or safety deficiencies;<br><br>3. Establish and implement plans to measure performance and set goals<br><br>4. Establish and implement plans to correct deficiencies, and to monitor the effects of these action plans on resident outcome;<br><br>5. Establish practices to systematically analyze underlying causes of deficiencies<br><br>6. Establish systems and processes to maintain documentation relative to the QAPI Program, as a basis for demonstrating that there is an effective ongoing program. Committee Membership<br><br>1. The Administrator shall appoint both committee members as designated below and shall appoint individuals to fill any vacancies occurring on the committee.<br><br>2. The following individuals will serve on the committee:<br><br>a. Administrator;<br><br>b. Director of Nursing Services;<br><br>c. Medical Director;<br><br>d. Dietary Representative;<br><br>e. Social Services Representative;<br><br>(continued on next page) |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | f. Activities Representative;<br><br>g. Environmental Services Representative;<br><br>h. Rehabilitative Services Representative;<br><br>i. Business office.<br><br>During an entrance conference on 03/11/25 at 9:34 AM, the Administrator was asked for a list of the QAPI committee members. A list was provided that included the Administrator, Director of Nursing (DON), the Medical Director, business office Manager (BOM), Minimum Data Set (MDS) Coordinator, Social Services, Activities, housekeeping, maintenance, therapy, dietician, pharmacy, Regional Nurse and the Director of Operations.<br><br>During an interview on 03/14/25 at 12:12 PM, the Administrator was asked about the QAPI Program, and an example of a Performance Improvement Projects (PIP)that was in progress. The Administrator stated QA was not currently working on a PIP due to not having the staffing in place to perform QAPI activity. The Administrator stated that staff had been meeting but there was no documentation or evidence that a QAPI program was in place. The Administrator was asked how the facility identified issues and worked on improvements. The Administrator stated there were several different meetings such as risk, infection control or clinical in which topics were discussed and reviewed but there just had not been the staff for QAPI. The Administrator was asked about the list of committee members that had been provided when asked for. The Administrator stated that list is who the facility wants to have on the committee. The Administrator was asked to verify if the committee had met to discuss QAPI. The Administrator stated there had been a meeting on January 31 in which it was discussed about getting QAPI started.<br><br>During an interview on 03/14/25 at 1:14 PM, the Medical Director was asked if she had participated in QAPI meetings since becoming the Medical Director. The Medical Director stated, No. |