

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145688	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2025
NAME OF PROVIDER OR SUPPLIER Princeton Rehab & Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE 255 West 69th Street Chicago, IL 60621	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39779</p> <p>Based on interview and record review the facility failed to a.) follow a physician's order and b.) failed to relay the need for a physician order and implement a system to ensure that specific treatments or procedures, which requires a physician's order, were being carried out for 1 (R1) of 3 (R5, R7) residents reviewed for therapy services. This failure has the potential to affect the effectiveness of patient care and lead to improper/delayed treatment.</p> <p>Findings Include:</p> <p>R1 was admitted to the facility on [DATE] with diagnosis not limited to Essential (Primary) Hypertension, Syphilis, Gastrostomy, Asthma with (Acute) Exacerbation, Dysphagia, Oropharyngeal Phase, Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation, Acute on Chronic Systolic (Congestive) Heart Failure, Long Term (Current) use of Anticoagulants, Epilepsy, Human Immunodeficiency Virus [HIV] Disease, Single Subsegmental Thrombotic Pulmonary Embolism, Ventricular Tachycardia, Polyneuropathy, Dysphagia Following Cerebral Infarction, Adjustment Disorder with Depressed Mood, Vascular Dementia, Sepsis, Hypoxemia and Hypotension. R1's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 00 indicating R1 was not able to answer the questions in Section C Cognitive Pattern.</p> <p>Order Summary Report dated 01/13/25 document in part: May evaluate and treat: PT/OT (Physical Therapy/Occupational Therapy).</p> <p>R1's Physical Therapy evaluation is dated 05/08/24 with a discharge date of [DATE]. R1's Occupational Therapy evaluation is dated 05/06/24 with a discharge date of [DATE]. There are no additional documented Physical/Occupational Therapy notes/evaluations for the physician order dated 01/13/25.</p> <p>On 04/22/25 at 12:37 PM R1 was observed lying in bed in a low [NAME] position. R1 responded yes to each question that was asked by the surveyor even while pointing to no on the paper that was held by the surveyor with written yes/no responses.</p> <p>On 04/22/24 at 11:16 AM V4 (R1's Family Member) stated the requested rehabilitation facility did an assessment, and it took 2 1/2 weeks before the facility sent the paperwork.</p> <p>On 04/22/25 at 11:23 AM V7 (R1's Family Friend/Care Giver) stated The facility faxed the medical records over to the requested rehabilitation facility.</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/22/25 at 12:08 PM V6 (R1's Power of Attorney) stated V5 (Requested Rehabilitation Facility Nurse) said she (V5) need the Occupational Therapy and Physical Therapy evaluation.</p> <p>On 04/22/25 at 11:41 AM V5 (Requested Rehabilitation Facility Nurse) stated the family wanted R1 to come to the requested rehabilitation facility. I can't get the therapy evaluations. R1 is not getting therapy so there is not anything to send so that I would have the physical therapy and occupational therapy evaluation to submit to the insurance. I got medical records from the facility, but it took a long time. I can't do anything until I get the therapy evaluation. It has been a couple of weeks since I received documentation from the facility. I received the documentation on 04/11/25. I am idling and asked the family to help. Sometimes the facility responds and a lot of times I would be sent to a phone that rings and rings. The case has been opened for a while, 6-8 weeks. I spoke to the family last week and told them I needed their help so I can submit it to the insurance.</p> <p>On 04/22/25 at 01:19 PM V8 (Licensed Practical Nurse) stated I think they are trying to get R1 in the requested rehabilitation facility. I know the paperwork has been sent to V5 (Requested Rehabilitation Facility Nurse) on 04/11/25. R1 is not receiving any current physical or occupational therapy.</p> <p>On 04/22/25 at 01:27 PM V11 (Certified Nurse Assistant) stated I contacted V5 (Requested Rehabilitation Facility Nurse) if she (V5) has what she (V5) needs for insurance purposes for R1 to get evaluated by one of their doctors. V4</p> <p>(R1's Family Member) has been requesting for R1 to go to the requested rehabilitation facility. I sent over what I have to the requested rehabilitation facility, and it depends on if the insurance will approve it. I did a follow-up last Thursday 04/17/25 and V5 (Requested Rehabilitation Facility Nurse) was not in the office.</p> <p>On 04/23/25 at 10:47 AM V15 (PTA/Physical Therapy Assistant/ Director of Rehab) stated R1 received physical therapy and occupational therapy in May of 2024. The physical therapy initial evaluation was on 05/08/24. The physical therapy discharge date was 05/28/24. The occupational initial evaluation was on 05/06/24. The occupational therapy discharge date was 05/23/24. Reevaluation for physical and occupational therapy after a hospital discharge depends on what warrants it. We don't necessarily pick a resident back up for therapy. We screen quarterly and talk to the staff on the floor if they notice any improvements or decline or if the doctor gives a referral. We can only do evaluations if we get a doctor's order.</p> <p>On 04/23/25 at 12:34 PM V14 (Social Service Director) stated I am learning about R1's family request for a transfer. I was on vacation when all of this came about and the requested rehabilitation facility reached out to the facility. I did not know that V11 (Certified Nurse Assistant) sent a packet to the requested rehabilitation facility.</p> <p>On 04/23/25 at 12:58 PM V14 (Social Service Director) presented the surveyor with R1's face sheet, labs and progress notes that was sent to the requested rehabilitation facility. V14 stated I am going to speak with the administrator.</p> <p>On 04/23/25 at 01:05 PM V14 (Social Service Director) stated the plan is we are going to obtain orders from the physician for the physical and occupational therapy evaluation and once we obtain the order, we will do the evaluation and send the results to the requested rehabilitation facility. I can't give you and answer why the evaluation was not done.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/23/25 at 01:44 PM V14 (Social Service Director) presented the surveyor with an order for R1's occupational and physical therapy evaluation. V14 said here is the order.</p> <p>On 04/23/25 at 02:29 PM V1 (Administrator) stated one day V4 (R1's Family Member) came up here. R1 use to be at the requested rehabilitation facility and V4 wanted R1 to go back to the facility. V4 said V5 (Requested Rehabilitation Facility Nurse) was trying to contact V14 (Social Service Director). I told V4 that V14 was on vacation and to have V5 call me. V11 (Certified Nurse Assistant) our scheduler for appointments called V5 about a follow up for another resident and got into what V5 needed, a doctor order for therapy services. V5 never called me directly for R1. V11 just told me yesterday that R1 needed an order to be evaluated by physical and occupational therapy.</p> <p>On 04/23/25 at 02:34 PM V3 (Director of Nursing) said we followed up with the nurse practitioner today and got an order for R1's physical and occupational therapy evaluation. The order was just written today. I let V15 (PTA/Physical Therapy Assistant/Director of Rehab) know and V15 said that she (V15) will do the evaluation first thing in the morning.</p> <p>On 04/23/25 at 02:41 PM V11 (Certified Nurse Assistant) stated I sent V5 (Requested Rehabilitation Facility Nurse) R1's documentation on 04/11/25. V5 told me R1 needed an evaluation for physical and occupational therapy. V14 (Social Service Director) was on vacation, and I talked to V20 (Resident Care Coordinator) MDS (Minimum Data Set) and she (V20) said that she (V20) was going to look into R1's chart.</p> <p>Progress note dated 03/07/25 08:07 document in part: MD (Medical Doctor) Progress Note Text: R1 would benefit from the requested rehab center. Resident was a total care before, but now only needs 1 person assist, a lot of improvement is needed. They (R1) will benefit from the requested rehabilitation facility outpatient therapy.</p> <p>Progress note dated 04/22/25 12:54 document I part: Social Services Note Text: Resident's family is requesting for a discharge to the requested rehabilitation facility for therapy. This is pending acceptance, therefore discharge plans will be initiated, if accepted.</p> <p>Order Summary dated 04/23/25 document in part: PT/OT evaluation only.</p> <p>On 04/23/25 V1 (Administrator) emailed an Employee Counseling Form for V11 (Certified Nurse Assistant) dated 04/23/25 documenting in part: Problem: Staff member failed to notify management team timely of orders needed for evaluation to send over to the requested rehabilitation facility for further review. Resolution of Problem or Action Taken: Staff member educated on the importance of effective communication.</p> <p>On 04/24/25 surveyor requested a Policy on Effective communication & Timely notification for a physician order. V1 (Administrator) sent an email at 07:48 PM documenting: We do not have a Policy on Effective communication & Timely notification for a physician order.</p> <p>On 04/25/25 at 02:13 PM V1 (Administrator) stated V3 (Director of Nursing) would be responsible for making sure the physician order for the PT/OT was carried out. I talked to V20 (Resident Care Coordinator) and V20 said that V11 (Certified Nurse Assistant) never disclosed that R1 needed a PT/OT evaluation. V20 set up a care plan meeting with V6 (R1's Power of Attorney) but V6 did not show up.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45110</p> <p>Based on observations, interviews and record reviews, the facility failed to provide, (A) incontinence care, (B) assistance with oral hygiene for five [R1, R3, R4, R5, R6] out of five residents who requires assistance with activities of daily living in a total sample of seven residents</p> <p>Findings Include,</p> <p>R1's clinical record indicates in part: R1'a medical diagnosis includes but not limited to dysplasia of anus, syphilis, gastrostomy, asthma, dysphagia, oropharyngeal phase, chronic obstructive pulmonary disease, acute chronic congestive heart failure, seizure disorder, human immunodeficiency virus HIV disease, pulmonary embolism, tachycardia, cerebral infarction stroke, constipation, vitamin D deficiency, anemia, depressive mood disorder, sepsis, hypotension, and essential hypertension.</p> <p>R1 has an ADL Functional Performance Deficit due to incontinence of bowel and bladder, aphasia, recent stroke limited mobility, and dysphagia: Assist with ADL tasks, assist with locomotion, and assist with personal hygiene.</p> <p>R1 requires assistance from staff in the area of personal grooming. a nursing rehab: dressing a grooming goal: R1 will participate in grooming daily, washing her face, combing her hair and brushing her teeth while listening to verbal cueing from staff daily as tolerated.</p> <p>R1's minimum data set section GG document in part:</p> <p>1/24/25, R1 need maximal assistance with ADL care, and oral care.</p> <p>R1's care plan document in part:</p> <p>R1 has an ADL functional performance deficit due to recent stroke and limited mobility; staff to assist with personal hygiene.</p> <p>On 4/22/25 at 12:39 PM, observed R1 resting in bed alert and oriented x3. R1 was none verbal but was able to point to answer yes or no questions appropriately. Gastric tube feeding per bed side. Noted R1's lips with dried white and red substance. Inside R1's mouth noted thick layers of white, yellow, brown substances covering teeth, gums, and tongue area.</p> <p>R1 was asked the following questions using the yes or no paper:</p> <p>Are you lying in bed right now? R1 pointed yes.</p> <p>Is your last name R1's last name asked by surveyor R1 pointed to yes.</p> <p>Do you receive oral care, such as teeth brushing? R1 pointed No.</p> <p>Do you receive showers and bed baths? R1 pointed No.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Are kept clean and dry? R1 pointed yes.</p> <p>R1's Care plan:</p> <p>R1 has an ADL Functional Performance Deficit due to incontinence of bowel and bladder, aphasia, recent stroke limited mobility, and dysphagia: Assist with ADL tasks, assist with locomotion, and assist with personal hygiene. R1 requires assistance from staff in the area of personal grooming. a nursing rehab: dressing a grooming goal: R1 will participate in grooming daily, washing her face, combing her hair and brushing her teeth while listening to verbal cueing from staff daily as tolerated.</p> <p>R1's minimum data set section GG document in part:</p> <p>1/24/25, R1 need maximal assistance with ADL care, and oral care.</p> <p>R1's care plan document in part:</p> <p>R1 has an ADL functional performance deficit due to recent stroke and limited mobility; staff to assist with personal hygiene.</p> <p>Interviews:</p> <p>On 4/22/25 at 11:15AM V4 [R1's Friend/ Power of Health Care] stated, R1 has been drinking water and eating ice for the last six months. The facility nursing staff tells me and R1 that she cannot eat, nor drink anything, if so R1 would choke or aspirate. R1's mouth has a lot of white build up and now R1's teeth are discolored from all the oral neglect. I have complained to the nursing staff about oral care, but I was never done. R1 has a stroke and is unable to use her right hand to brush her teeth. R1 usually communicate with yes, unable to express her needs. However, R1 is alert and oriented. R1 is not able to write her thoughts down due to the stroke affecting her right hand.</p> <p>On 4/22/25 at 1:25 PM, R3 stated, I have an urostomy pouch that has been leaking for two days. This morning, I told V12 [Certified Nurse Assistant] , but no one came to change the pouch.</p> <p>On 4/22/25 at 1:30 PM, V12 [Certified Nurse Assistant] stated, When I made rounds this morning and R3 told me she was okay. R3's urostomy has been leaking off and on about a month. When her urostomy was leaking this morning but the nurses already know. I am not allowed to change the pouch; I just placed a bath towel under the pouch to catch the urine. I cannot remember if I told the nurse R3's urine pouch was leaking this morning.</p> <p>On 4/22/25 at 1:35 PM, V19 [Licensed Practical Nurse] and surveyor observed R3 resting in bed with R3 holding a wash towel on her side. Noted yellow brownish large circle stain on the bed linen.</p> <p>On 4/22/25 at 1:50PM, V19 [Licensed Practical Nurse] stated, I was made aware this morning that R3's urostomy was leaking, but I just got the supplies to change the urostomy. On this floor we did not have the wafers needed for me to change the urostomy. I received the supplies a couple of hours ago. I been busy today, I will replace R3's urostomy pouch now.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R3' clinical record indicates in part: R3 was admitted with cerebral infarction, hemiplegia and hemiparesis, artificial opening of urinary tract, aphasia, dysphagia, gastrostomy, chronic heart failure, chronic pulmonary disease, gout, and malignant neoplasm of cervix. R3's minimum data set indicates R3 is alert and oriented x3, able to make her needs known.</p> <p>R3's Minimum Data Set, dated dated dated [DATE]; R3 is dependent with toileting hygiene and managing ostomy care.</p> <p>R3's care plan: R3 requires an urostomy. Staff to perform ostomy care.</p> <p>R3's physician order:</p> <p>6/6/24; Urostomy care every shift and as needed.</p> <p>6/6/24: Monitor urostomy tube bag every shift and record urine output every shift.</p> <p>On 4/22/25 at 1:00 PM, surveyor and V9 [Registered Nurse] observed R4 resting in bed with gastric feeding infusing. V9 asked R4 to open his mouth and noted R4's tongue completely covered in thick white milking substance, with yellowish dark substance covering R4's teeth.</p> <p>On 4/22/25 at 1:05 PM, V9 [Registered Nurse] stated R4 receives gastric tube feeding and oral pleasure feedings. I am not sure what is on his tongue. R4 was admitted here from the hospital with oral thrush, maybe the white substance is oatmeal, I am not sure.</p> <p>R4's clinical record indicates; R4 admitted with gastrostomy, atrial fibrillation, dehydration, and gastro-esophageal reflux disease. Alert to self, no able to make his needs known. R4's minimum data set section GG indicates R4 is dependent with ADL oral care.</p> <p>On 4/22/25 at 12:55 PM, observed R5 resting in bed with a foul odor. R5 was alert x1, not able to make her needs known. V8 [Licensed Practical Nurse] with the surveyor present observed R5's bottom bed sheet with a dark brownish colored circle coming from underneath R5. Inside R5's under brief noted the brief was soaked with bowel movement from the back of the brief up to the top of the pubic area. R5's teeth were covered with a thick yellow brownish substance around the teeth and gums. V8 [Licensed Practical Nurse] stated, The odor is strong, the urine is soaked all the way through the under brief on to the bed linen. R5's needs her teeth brushed. I will have her clean up and oral hygiene.</p> <p>On 4/22/25 at 1:20PM, V17 [Certified Nurse Assistant] stated, I start my shift at 7AM. I checked on R5 at 10:30 AM and she was okay. I will clean R5 now. This is my first-time providing ADL care to R5 during my shift.</p> <p>R5's clinical record indicates R5 was admitted with cerebral infarction, hemiplegia and hemiparesis, gastrostomy, schizoaffective disorder, chronic embolism, heart failure, and type II diabetes. R5's minimum data set [MDS] indicates R5 is alert to self and is not cognitively intact. R5's MDs section GG indicates R5 is dependent for ADL and incontinent care.</p> <p>R5's Care Plan:</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R5 has limited ability to perform person hygiene task. Due to stroke with left sided hemiplegia and impaired cognition; Staff to assist with oral care, personal hygiene and toileting needs as necessary.</p> <p>R6 was resting in bed alert and oriented x3. Observed yellow, white, and brown debris on R6's teeth.</p> <p>On 4/22/25 at 3:00 PM R6 stated, I get my teeth brushes two to three times per week, just depends on who is working. The certified nurse assistant does not even provide me with the tooth bush, toothpaste or basin so I could try and brush my teeth. I need help from the staff while trying to brush my teeth.</p> <p>R6's clinical record indicates the following: R6 was admitted with human immunodeficiency virus [HIV] disease, chronic kidney disease stage 5, iron deficiency anemia, major depressive disorder, chronic obstructive pulmonary disease, cerebral infarction, weakness, gout, restlessness and agitation, arthritis, acute kidney disease, and hypertensive chronic kidney disease. R6 minimum data set indicates R6 is alert and oriented X3 able to make her needs known. R6's minimum data set section [GG]; R6 requires moderate assistance with oral hygiene.</p> <p>On 4/24/25 at 10:31 AM, V3 [Director of Nursing] stated All nursing staff should make rounds at least every two hours and as needed while answering the call lights and provide ADL care. If a resident is wet and need changing from incontinence or urostomy need changing the care should be provided right away. If incontinent care is not provided timely it could potentially cause skin alterations and or urinary infections. Oral care is part of the daily ADL care. All residents need their teeth brushed daily. If not, it could potentially cause tooth decay or oral infections. Nursing staff were in-serviced on ADL, oral, urostomy care.</p> <p>On 4/25/25 at 9:31 AM, V1 [Administrator] stated The facility does not have any ADL, incontinent care policy. The facility follows the standard of care. The nursing staff will provide showers at least twice per week and daily bed bath. The nursing staff will change residents timely and as needed.</p> <p>Policy:</p> <p>Resident Rights Ombudsman</p> <p>Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life.</p> <p>483.24 (All)(2)</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming and personal and oral hygiene.</p>		