

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/06/2025
NAME OF PROVIDER OR SUPPLIER  Ryze on the Avenue		STREET ADDRESS, CITY, STATE, ZIP CODE  3400 South Indiana Chicago, IL 60616	

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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure call lights are answered in a timely manner for one resident (R4) in the sample of 8 residents reviewed for call lights. Findings include: R4's Face Sheet documents resident is a [AGE] year-old with diagnoses including but not limited to: Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, speech and language deficits following cerebral infarction, major depressive disorder. Minimum Data Set Section (MDS) section C (dated Jun 24, 2025) documents that R4 has an Interview for Mental Status (BIMS) score of 15, indicating that R4's cognition is intact. Minimum Data Set Section (MDS) section GG (dated Jun 24, 2025) documents that R4 utilizes a walker and requires supervision with toileting. Care plan (dated 12/10/2024) documents that R4 has a diagnosis of/history of cerebral vascular accident with right side residual effects. On 07/29/2025 at 11:02AM, surveyor was conducting an interview with R4. R4 verbalized that he needs staff assistance and R4 ignited the call light system at 11:05AM. Surveyor remained in the room the entire time R4 waited for staff to answer the call light. At 11:11AM, surveyor observed a staff member dressed in a purple scrub uniform (identified as a certified nursing assistant) walking past R4's room and not answering R4's call light. At 11:16AM, surveyor observed R4's call light being answered by V3 (Assistant Director of Nursing). V3 assisted R4 with his needs. R4 waited for a total of 11 minutes for his call light to be answered. On 07/29/2025 at 11:30am, R7 (R4's roommate) stated, R4 had a stroke, and he walks with a walker. R4 needs staff assistance when he goes to the restroom because he cannot put his pants on by himself. At times, R4 will put on the call light and staff will take hours to answer the call light. This happens a lot. I try to help R4 as much as I can. The nurses and certified nursing assistants bring their personal problems to work and talk about this personal issues instead of helping the residents. On 07/29/2025 at 2:57PM, V2 (Director of Nursing) stated, The expectation for call lights is that the staff will answer the call lights within a timely manner. Sometimes staff are not able to answer the resident call lights in a timely manner because there is a code, which is understandable. I think 3 to 5 minutes is an acceptable time for a resident to wait on staff to answer a call light. I answer call lights right away and acknowledge the resident's needs immediately. I never leave a resident waiting to have their call lights answered for 11 minutes because I answer the call lights right away. It is never acceptable for any staff to walk past a resident's call light and not answer it. It is never okay to walk past a call light and not answer it. I will do an in-service with the nurses and the certified nursing assistants about making sure that resident call lights are answered promptly. On 08/01/2025 at 12:20PM, V1 (Administrator) stated, An acceptable amount of time for a resident to wait to get their call light answered is between 5 to 10 minutes, depending on the situation. The certified nursing assistants are wearing purple uniforms. It is not the facility's policy for a certified nursing assistant or any staff member to walk past a resident's call light and not answer it and see what the resident needs. Call Light Response Policy (dated 01/10/2024) documents in part: To provide the staff with guidance on responding to residents' requests and needs. Answer the patient or resident's call as soon as possible.</p>		