

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145661	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2024
NAME OF PROVIDER OR SUPPLIER Ryze West		STREET ADDRESS, CITY, STATE, ZIP CODE 5130 West Jackson Boulevard Chicago, IL 60644	

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39779</p> <p>Based on observation, interview, and record review the facility failed to provide proper positioning for 1 (R1) resident during dining. This failure has the potential for R1 to be at risk for choking and aspiration during dining experience.</p> <p>Findings Include:</p> <p>R1 has diagnosis not limited to Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side, Aphasia Following Cerebral Infarction, Essential (Primary) Hypertension, Atrial Fibrillation, Type 2 Diabetes Mellitus, Anxiety Disorder due to Known Physiological Condition and Post-Traumatic Stress Disorder. R1's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 04 indicating severe cognitive impairment.</p> <p>R1's Care Plan document in part: Focus: Bed Mobility: R1 has a self-care deficit in bed mobility r/t (related/to) (Decreased ability to position or reposition self in bed/ Turn from side to side/ Move from lying to sitting or sitting to lying position). Intervention: Position and reposition resident in bed for comfort, joint support, and skin integrity.</p> <p>During the initial tour of the facility on 09/10/24 at 01:05 PM, the surveyor observed R1 in bed in a low fowlers position with the meal tray in front of him while trying to eat lunch from an overbed table. R1's reclined body was level with the overbed table and R1 was drinking thin red liquid from a cup.</p> <p>On 09/10/24 at 01:11 PM Surveyor went to the nurse station and asked V7 (Licensed Practical Nurse) to go to R1's room. Surveyor asked V7 R1's position in bed. V7 responded, R1 is in a low [NAME] position. R1 should be up right in bed. The position that R1 is in is not appropriate for eating. There is a potential for choking or R1 may aspirate.</p> <p>On 09/10/24 at 01:14 PM while waiting for staff to reposition R1, R1 was observed coughing. V7 (Licensed Practical Nurse) was standing near the foot of R1's bed then stated, let me get some gloves, I got someone on the way to help pull you (R1) up.</p> <p>On 09/10/24 at 01:22 PM the nurse and certified nurse assistant repositioned R1 in bed.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/11/24 at 12:14 PM surveyor asked V9 (Certified Nurse Assistant) what the correct positioning of a resident in bed while eating. V9 responded, the position of the residents while eating in bed is 90 degree.</p> <p>On 09/11/24 at 03:03 PM V11 (3rd floor unit manager) was asked the correct positioning of a resident while eating in bed. V11 responded, the resident should be in an upright position when eating or being fed.</p> <p>On 09/12/24 10:26 AM V17 (Licensed Practical Nurse/Restorative Nurse) stated R1 is a substantial assist with toileting and sitting up in the bed. R1 was supervision with eating up until this week. R1 need assistance with eating because he is not eating well. The position that a resident should be in when eating or being fed in bed should be a semi-Fowler position, sitting up to prevent aspiration.</p> <p>Document undated document in part: R1 requires assistance with dining.</p> <p>In-Service, Education and Staff Development undated documents in part: Topic: It is the expectation that restorative aides' complete rounds on residents requiring assistance dining to ensure that they are positioned appropriately prior to the arrival of floor trays.</p> <p>In-Service, Education and Staff Development undated documents in part: Topic: Resident should be positioned in semi to high [NAME]'s position during mealtimes to prevent aspiration and/or choking and to promote optimal intake.</p> <p>Policy:</p> <p>Titled Feeding Assistance revised 01/24 document in part: General: To attempt to provide adequate nutrition to a resident. Guideline: 3. Position resident in proper body alignment for eating.</p> <p>Titled Activities of Daily Living reviewed 05/24 document in part: General: A program of activities of daily living is to prevent disability and return or maintain residents at their maximal level of functioning based on their diagnosis. D. Feeding a. Proper positioning for eating is maintained.</p>		