STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145661	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ryze West	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)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49666 The facility failed to ensure the resident's call light device was within reach for two residents (R1, R3) out of three residents reviewed for quality of care. This failed practice placed the resident at risk for not being able to call for help, if needed. Findings include: On 10/22/2024, 10:41 AM R1's call light was on top of 3 pillows without pillowcases that are on top of R1's nightstand. R1 was sleeping, easily arousable, and in no apparent distress. R1 states that she is not sure when she first came to the facility. R1 states I have memory loss, maybe about 6 months ago, I don't like it here. R1 cannot remember the names of the staff that take away her call light. R1 states that when they do come to check on her, R1 states that she forgets what she even yelled out for. R1 cannot remember when she yelled out for help. R1 states that currently, she cannot reach her call button. R1 states look and see they took it away from me, I can't reach it. On 10/22/2024, 10:55 AM V3 (Certified Nursing Assistant) states that call lights must be in reach of the residents. V3 states that she has not heard any resident yell out for help. V3 reports that residents who are more vulnerable and must have their call light within reach is contracted, if a resident has some confusion, or residents that are non-verbal or non-ambulatory. V3 states that residents should not be ignored if they are yelling for help because they might need or want something, or they can be slipping. V3 and surveyor entered R1's room and V3 states that R1's call light is not within reach. V3 grabbed R1's call button that is on top of the pillows on the nightstand and placed it within R1's reach. R1 states thank you. V3 states that she has not taken away call lights form any resident because that is neglect. R1's Face sheet documents that R1 is a [AGE] year-old female admitted to the facility on [DATE], who has diagnoses not limited to: paraplegia, major depressive disorder, insomnia due to other mental disorder, bipolar disorder. R1's Minimum Data Set (MDS) Section C, dated 10/02/2024, documents R1 has a Brief Interview for Mental Status (BIMS) of 12 out of 15, R1 is moderately cognitive impaired. R1's Minimum Data Set (MDS) section GG dated 10/02/2024, documents in part R1 needs substantial/maximal assistance for ability to roll from lying on back to left and right side and return to lying on back on the bed. (continued on next page)

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
	145661	A. Building B. Wing	10/25/2024

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Ryze West	5130 West Jackson Boulevard Chicago, IL 60644

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/22/2024, 11:05 AM R3 was lying in bed, covered in a white sheet, in no apparent distress. R3's call button attached to the lowest part of the right bed side rail. R3 states I need a diaper change; I don't have the call light as R3 looked around for his call button. On 10/23/2024, 10:09 AM R3's call light button noted on the floor. R3 states that his nurse gave him some medicine earlier. On 10/23/2024, 10:12 AM surveyor and V9 (Licensed Practical Nurse) entered R3's room and V9 states that the call button should not be on the floor. V9 states it probably slipped off of him. It was on his chest. I did initially go to him because he pulled the call light. V9 states that she did not move R3's call light away from him. V9 denies any resident complaining of this to her. V9 states that it is important for residents to have their call light within reach just in case an emergency happens or if they ask for something simple as some water. R3's Face sheet documents that R3 is a [AGE] year-old male admitted to the facility on [DATE], who has diagnoses not limited to: adult failure to thrive, history of falling, syncope and collapse, generalized anxiety disorder, major depressive disorder, recurrent, unspecified, legal blindness. R3's Minimum Data Set (MDS), dated [DATE], documents R3 has a Brief Interview for Mental Status (BIMS) of 14 out of 15, indicating R3 is cognitively intact. R3's care plan dated 5/14/2024 documents in part R3 has a potential for falls. R3 had an actual fall. Interventions include encourage to utilize call light for staff assistance, have commonly used items within reach. Facility policy dated 01/10/2024, titled Call Light Response documents in part, to provide the staff with guidance on responding to residents' requests and needs. Ensure the call light is always within the resident's reach. When the patient or resident is in bed or confined to a bed or chair, provide the call light within easy reach of the patient or resident.