

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  05/22/2025
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 0880</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40067</b></p> <p>Based on interview and record review, the facility failed to administer ordered topical medication used for lice and scabies exposure; failed to document notification of physician and or nurse practitioner of residents' exposure to lice and scabies; failed to obtain an order for Contact precautions for lice and scabies isolation; failed to perform isolation assessments and infection criteria evaluations for residents exposed to lice and scabies; failed to perform a proper room deep cleaning for residents exposed to lice and scabies; and failed to follow their facility policies for residents with confirmed cases of and exposure to lice and scabies. These failures resulted in R2 experiencing one occurrence of scabies and two occurrences of lice; R4 experiencing one occurrence of head lice; and R1 experiencing psychosocial harm from exposure to scabies and lice in the sample of 4 residents (R1, R2, R4 and R7) reviewed for infection control.</p> <p>Findings include:</p> <p>1) On 5/19/25 at 10:30 am, R1 observed in R1's room, well dressed and groomed and walking independently. Contact Precautions sign posted on R1, R2 and R4's door with a PPE (personal protective equipment) bin located outside their door. R1 stated that R1 moved into this current room on 3/19/25 after another resident (R7) moved to a different room on the floor. R1 said that the staff informed R1 that the room was cleaned before R1 moved in. R1 stated that R1 recently saw R2 scratching R2's self and reported it to the nursing staff. R1 stated that an unknown nursing staff informed R1 that the staff saw nits and scabies on R2's body, and R2 moves around the facility and goes out to the smoking patio. R1 stated that R1 follows R2 in the bathroom and see's spots of blood on the toilet seat where R2 has scratched R2's skin scabies bites, and R1 tries to clean it prior to R1's use of the toilet. R1 stated, I have to protect myself because my immune system is low. R1 stated that when the CNA (Certified Nursing Assistant, V3) was bagging up their clothes in the room for washing, V3 bagged all of their clothes (R1, R2 and R4) together in a special bag. R1 stated that R1 told V3 that R1 was putting R1's clothes in a separate bag because R1 didn't want the bugs contaminating R1's clothes, saying That's just not right. R1 stated that V3 responded back saying that V3 didn't want to stay in our room too long. R1 stated that this is not a life and death situation for staff to come into R1's room, but questions if staff know how R1 feels. R1 stated that being exposed and treated for lice and scabies in the facility makes R1 feel horrible and it's all I can think about. How would you feel? They aren't doing enough to stop this contamination.</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 0880</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 5/21/25 at 11:39 AM, R1 stated that V22 (Assistant Administrator) spoke to R1 about the deep cleaning that was done for R1's room after the recent lice and scabies exposure. R1 stated, It's the same curtains that are hanging up with the same stains on them and that they were not changed during R1's deep room cleaning. When asked about R1 being offered a commode for a different toileting option, R1 stated no.</p> <p>R1's Admission Record documents, in part, diagnoses of systemic lupus erythematosus, primary osteoarthritis, anemia, anxiety disorder, depression, insomnia, pain in right arm, pain in right shoulder, and shortness of breath.</p> <p>R1's Census List indicates that R1 resided in the same facility room with R2 and R4 since 3/19/25.</p> <p>R1's Minimum Data Set (MDS), dated [DATE], documents, in part, a Brief Interview for Mental Status (BIMS) score of 15 which indicates that R1 is cognitively intact.</p> <p>In R1's Progress Notes, on 5/13/25 at 9:03 AM, V18 (Infectious Disease Nurse Practitioner) documents, in part, that R1 was being treated for exposure to an infectious rash from roommate a plan as follows: Treatment and deep clean of room need to be concurrent (or else pt {patient} risks reinoculation); Recommend room be deep cleaned; Recommend all launderable items in the room are washed in hot water and dried on high heat. Items that cannot be laundered should be placed in a sealed, air-tight back for a minimum of 72 hours with treatment of Permethrin Cream 5% at bedtime and oral Ivermectin.</p> <p>Facility Contact Precautions sign (undated) documents, Stop. Contact Precautions. Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and Staff Must Also: Put on gloves before room entry. Discard gloves before room exit. Put on gowns before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person.</p> <p>2) On 5/19/25 at 10:42 am, R2 observed laying in bed with a rollator walker next to R2. R2 observed R2 scratching legs under R2's pants and asked about R2 scratching. R2 stated that R2 was rubbing the leg and showed this surveyor R2's legs with dry skin. R2 showed this surveyor R2's bilateral arms and shoulders by pulling up shirt sleeve, and surveyor noted small, pinpoint, dried scabs and lotion residue noted. R2 stated that R2 could not recall specific dates but does remember have bites from bugs on R2's body. R2 stated that R2 did receive a cream last week for treatment of the bugs, but R2 does not know the medication or when R2 received it.</p> <p>On 5/20/25 at 9:57 am, R2 stated that R2 has been using the toilet in their bathroom. When asked about R2's shorter haircut, R2 stated that the staff recently cut R2's hair.</p> <p>R2's Admission Record documents, in part, diagnoses of dementia, epilepsy, seizures, asthma respiratory failure, chronic obstructive pulmonary disease, personal history of pneumonia, hereditary and idiopathic neuropathy, encephalopathy, hypokalemia, altered mental status, reduced mobility, anemia, chronic systolic (congestive) heart failure, hypertension, hyperlipidemia and cognitive communication deficit.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>R2's MDS, dated [DATE], documents, in part, a BIMS score 9 which indicates that R2 has moderate cognitive impairment.</p> <p>R2's Census List indicates that R2 resides in the same facility room since 7/18/24 which is the same room with R1 and R4 since 3/19/25 and with R2 and R7 from February 2025 to 3/19/25.</p> <p>In R2's Progress Notes, dated 2/14/25 at 10:35 AM, V11 (Nurse Practitioner, NP) documents, in part, that R2 is being seen for scabies exposure due to roommate (R7) just got diagnosed with scabies by an outside provider and that V11 is ordering Permethrin for prophylaxis.</p> <p>In R2's Progress Notes, dated 3/10/25 at 5:00 PM, V12 (Licensed Practical Nurse, LPN/Unit Manager) documents, in part, that R2 complained of itchiness to right arm. Writer assessed patient (R2) noted redness and irritation to right arm inner fold; that V11 (NP) was notified with orders received to apply Permethrin Cream 5% to entire body topically x 1 at bedtime.</p> <p>On 5/21/25 at 10:38 AM, V12 (LPN/Unit Manager) stated that on 3/10/25, R2 complained of itchiness and that V12 performed a skin assessment of R2 showing skin abnormalities. V12 stated that the purpose of Permethrin is to kill the infection. V12 stated that an unknown CNA seen some bugs in R2's room on 3/10/25, but I didn't see anything. When asked where did V12 document this account of seeing bugs near R2 and R2 scratching self, V12 stated, I didn't see any bugs. I didn't see bugs. I saw itching. CNA saw the bugs. V12 stated that V12 notified V18 (NP) who ordered R2's Permethrin cream 5% on 3/10/25, and this medication comes from pharmacy. V12 stated that V12 did not administer R2's Permethrin 5 % cream as ordered on 3/10/25. V12 stated that V12 would document administration of Permethrin cream for R2 on the eMAR by clicking administer to obtain a check mar or in an eMAR progress note.</p> <p>In R2's Progress Notes, dated 3/11/25 at 9:15 AM, V11 (NP) documents, in part, that R2 is being seen due to skin irritation and with insects found in the room on Monday (3/10/25). Resident with bites to arms and back, redness and scabs noted since Monday. Endorses itchiness. V11 ordered Permethrin Cream, Benadryl and room deep cleaning.</p> <p>In R2's Progress Notes, dated 5/12/25 at 9:50 AM, V11 (NP) documents, in part, that R2 is being seen for body lice infestation. This writer was called to the shower room by NOD (nurse on duty). When this writer entered the shower room, and walked up to the shower chair, there was a t-shirt and a pair of sweatpants with a significant amount of tiny, light tan bugs crawling around on the clothes, mostly around the neck/upper back portion of the t-shirt. The clothes were identified as (R2's). V11 further documents, in part, that R2 was assessed by V11 with raw areas from scratching with redness to the neck and upper back, and V11 ordered Permethrin cream and Contact isolation per infection department protocol.</p> <p>In R2's Progress Notes, dated 5/13/25 at 9:26 PM, V18 (Infectious Disease NP) documents, in part, that R2 is being evaluated for a pruritic rash with noting R2's skin with maculopapular rash on BLE (bilateral lower extremities), abdomen; burrows visualized with a diagnosis of scabies. V18's plan for R2 is as follows: Treatment and deep clean of room need to be concurrent (or else pt risks reinoculation); Recommend room be deep cleaned; Recommend all launderable items in the room are washed in hot water and dried on high heat. Items that cannot be laundered should be placed in a sealed, air-tight bag for a minimum of 72 hours with treatment of Permethrin Cream 5% at bedtime, oral Ivermectin, and contact precautions.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>3) On 5/19/25 at 10:46 AM, R4 observed laying in bed with gown on and groomed. R1 has pulled the cloth privacy curtain hanging in between R1 and R4's bed during R4's interview. This surveyor noted small tan discolorations on the cream-colored privacy curtain. R4 stated that R4 did receive a special cream over R4's body last week, but R4 could not remember specific dates of when R4 may have been exposed or treated for lice or scabies or previous treatments. R4 stated that R4 needs one staff member to help turn in bed, change incontinence brief and to be transferred from the bed to R4's wheelchair.</p> <p>On 5/20/25 at 9:57 am, R4 stated that the nursing staff cut R4's hair because they had to clean R4's head because R4 kept itching my head.</p> <p>R4's Admission Record documents, in part, diagnoses of type 2 diabetes mellitus, moderate protein-calorie malnutrition, chronic obstructive pulmonary disease, immunodeficiency due to conditions classified elsewhere, muscle weakness, peripheral vascular disease, major depressive disorder, lack of coordination, abnormalities of gait and mobility, heart failure, constipation, obesity, partial loss of teeth, chronic kidney disease stage 1, polyosteoarthritis, malignant neoplasm of left breast, acute embolism and thrombosis of right femoral vein, personal history of peptic ulcer disease, bradycardia, hypertension, and localized edema.</p> <p>R4's MDS, dated [DATE], documents, in part, a BIMS score 10 which indicates that R4 has moderate cognitive impairment.</p> <p>R4's Census List indicates that R4 resides in the same facility room since 7/16/24 which is the same room with R1 and R2 since 3/19/25 and with R2 and R7 from February 2025 to 3/19/25.</p> <p>In R4's Progress Notes, dated 2/14/25 at 10:35 AM, V11 (NP) documents, in part, that R4 was being seen for scabies exposure due to roommate (R7) just got diagnosed with scabies by an outside provider and that V11 is ordering Permethrin for prophylaxis.</p> <p>In R4's Progress Notes, dated 3/10/25 at 3:40 PM, V9 (Registered Nurse, RN/Assistant Director of Nursing, ADON) documents, in part, Per NP request all patients in room are medicated due too (to) one roommate (roommate) having possible rash.</p> <p>On 5/21/25 at 10:10 am, V9 (RN, ADON) stated that all residents (R2, R4, and R7) were being treated due to R2's possible rash. V9 stated that V9 did assess R2 on 3/10/25 and saw some bite marks but didn't know what it was. V9 stated that residents placed on contact isolation need a physician's order placed in the EHR. When asked if R4 had a physician's order for contact isolation on 3/10/25, V9 stated, Not to my knowledge.</p> <p>In R4's Progress Notes, dated 5/13/25 at 4:49 PM, V18 (Infectious Disease NP) documents, in part, that R4 is being seen due to exposure to an infectious rash with R4 complaining of significant head pruritus, and that V18 discussed with primary and reported seeing nits two days ago. V18 documents a diagnosis of lice with exposure to scabies with recommended Permethrin shampoo, combing hair with lice comb; Room should be deep cleaned at the same time as pt receives treatment (or else (R4) risks reinoculation); All launderable items should be washed in hot water and dried on high heat. Items that cannot be laundered should be placed in a sealed, air-tight bag for at least 72 hrs (hours); and Contact precautions.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>R4's Order Summary Report (POS) which includes active, discontinued and completed orders from 2/1/25 to 5/21/25 documents, in part, the following:</p> <p>a) Order date of 2/13/25: Permethrin Cream 5 % Apply to entire body topically at bedtime for treatment for 1 Day Apply to entire body (From neck all the way down to the toes).</p> <p>b) Order date of 3/10/25: Permethrin Cream 5 % Apply to entire body topically at bedtime for treatment for 1 Day Apply to entire body (From neck all the way down to the toes).</p> <p>c) No Contact Isolation order is ordered for R4 for 2/13/25 or 3/10/25.</p> <p>R4's February 2025 Electronic Medication Administration Record (eMAR) documents, in part, the order of Permethrin Cream 5 % Apply to entire body topically at bedtime for treatment for 1 Day Apply to entire body (From neck all the way down to the toes) scheduled on 2/13/25 at 9:00 pm with a chart code: of 9 documented by V4 (LPN). R4's February 2025 eMAR Chart Codes display indicate 9=Other / See Nurse Notes.</p> <p>In R4's eMAR Progress Note, dated 2/13/2025 at 9:16 pm, V4 (LPN) documents, Note Text: Permethrin External Cream 5 %. Apply to Apply to entire body topically at bedtime for treatment for 1 Day Apply to entire body (From neck all the way down to the toes). On order.</p> <p>On 5/22/25 at 8:46 am, V4 (LPN) stated that V4 could not remember the details of R4's treatment order of Permethrin scheduled on 2/13/25, and V4 stated, I do know somebody had something in there (R2, R4, R7's room) but V4 cannot remember the exact organism. V4 stated that V4 remembers not having the Permethrin cream yet from pharmacy, meaning that it was still on order as V4 documented in the eMAR note on 2/13/25 at 9:16 pm, and this note was created by V4 with a 9 chart code that V4 documented. V4 stated that V4 if the medication comes later in the shift, V4 would have had to document administration of the Permethrin in a progress note at a later time, due to the eMAR already being documented with the 9 chart code. V4 stated if V4 did not document administration of R4's Permethrin on 2/13/25, V4 would have told the oncoming nurse of the pending administration and would have notified nurse practitioner or physician that the medication was being administered late. When informed that review of R4's progress notes from 2/10/25 to 2/17/25 show no progress note for notifying V4's NP or physician of this, V4 stated, I should have.</p> <p>Review of R4's Progress Notes from 2/10/25 to 2/17/25 show no nurses' documentation of administration of Permethrin Cream 5% on 2/13/25.</p> <p>R4's Isolation Assessment, dated 5/12/25 at 7:35 am, V16 documents, in part, that R4 requires transmission-based precautions related to Body lice with Contact precautions.</p> <p>R4's Infection Criteria Evaluation, dated 5/12/25 at 7:33 am, V16 documents, in part, that R2 has 2a maculopapular and/or itching rash.</p> <p>Review of R4's electronic health record (EHR) for Isolation Assessments and Infection Criteria Evaluations from 2/1/25 to 5/11/25 show none were performed. On 5/21/25 at 12:15 pm, this surveyor requested from V1 (Administrator) for R4's Isolation Assessments and Infection Criteria Evaluations prior to 5/12/25, and none were provided.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 5/22/25 at 9:35 AM, V17 (LPN) stated that V17 documented this Not available. Will administer upon arrival to indicate that at the time when V17 documented this note, the facility did not have the Permetherin cream from the pharmacy. V17 stated that V17 did not administer R7 the Permetherin cream on 2/14/25 indicated by the 9 on the eMAR to document that the medication is not available to administer. V17 stated that V17 then endorses to the following shift's nurse to administer the pending medication and that nurse will then document it as administered. V17 stated that V17 will also notify the nurse practitioner that the ordered medication is not available to administer at the scheduled time and will document this notification in the resident's EHR. V17 stated that for R7's Permetherin cream scheduled to be administered on 2/14/25, V17 stated that V17 could not remember if V17 notified V19 (Nurse Practitioner); would have to look through previous phone calls or texts; and if V19 was notified, V17 would have documented it in R7's progress notes. V17 stated that V17 could not remember exactly about R7's condition on 2/14/25, but Permetherin cream is used to treat lice or scabies.</p> <p>Review of R7's Progress Notes from 2/10/25 to 2/17/25 show no nurses' documentation of administration of Permethrin Cream 5% on 2/14/25, and there is no nurses' documentation present for notification of R7's nurse practitioner or physician for this new scabicide topical medication.</p> <p>Review of R7's EHR for Isolation Assessments and Infection Criteria Evaluations from 2/1/25 to 5/11/25 show none were performed during this time frame. On 5/21/25 at 4:54 pm, this surveyor requested from V1 (Administrator) for R7's two most recent Isolation Assessments and Infection Criteria Evaluations, and none were provided.</p> <p>On 5/20/25 at 10:07 AM, V5 (CNA) stated that V5 is the regular day shift CNA on R1, R2, R4 and R7's floor and normally assigned to R1, R2 and R4's current room. V5 stated that on two different days (unknown dates), V5 observed nits on R2's bed sheets and on R2's bag of clothes. V5 stated that R1 had notified V5 that R1 used the bathroom after R2 who left bugs on the toilet seat. V5 stated that V5 observed R2 frequently scratching R2's body, and V5 told several nurses about these situations, including V7 and V12. V5 stated that another resident, R7, moved to another room from R1, R2 and R4's current room. V5 stated, There was an infestation before in that room [ROOM NUMBER] to 3 months ago and it was not properly handled. V5 stated that only now that R1 is complaining about R2's scratching that something is happening.</p> <p>On 5/20/25 at 1:22 PM, V7 (LPN) stated that V7 works on R1, R2, R4 and R7's floor and is normally assigned to R1, R2, R4 and R7's rooms. V7 stated that R2 moves throughout the building, goes out to smoke but mostly stays in R2's room. When asked why was R1, R2, and R4 on Contact precautions as of 5/19/25, V7 stated, Lice is what I have been told. V7 stated that R2 had lice, and that R1, R2, and R4 needed to be treated. V7 stated, Bugs travel. When asked about reports (from R1 and V5) of R2's frequent body scratching, V7 stated, If (R2) was scratching, I did not paid attention to it. V7 stated, I did not see (R2) scratching. No one told me.</p> <p>(continued on next page)</p>		

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  05/22/2025
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 0880</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 5/20/25 at 2:58 PM, V8 (Housekeeping Director) stated that deep cleans are performed by housekeeping staff when nurse manager or Infection Preventionist nurse lets V8 know to do a deep clean when a resident(s) may have lice or scabies. V8 stated that the CNAs will bag up all clothes of those residents in the room in special melt away bags than disintegrate when laundered at 130 to 140 degrees Fahrenheit. V8 stated that each resident's clothes are bagged in a different melt away bag and washed and dried separately. V8 stated, The heat kills the bugs. V8 stated that every surface is cleaned with bleach in the room, and the residents are out of the room while this is being done. V8 added that deep cleans of rooms are also done on a normal basis about 1 time a month, and housekeeping staff document all deep cleans of rooms. V8 stated that for R1, R2, and R4's current room, a deep clean was just done last week, and it was not scabies, only lice. V8 stated that V8 has worked as the facility's housekeeping director since September 2024 and that a deep clean due to lice or scabies was not done prior to May 2025.</p> <p>On 5/20/25 at 3:40 pm, after V8's interview was completed and V8 left the conference room with surveyor, V8 returns to this surveyor asking if this surveyor had asked V8 about prior deep cleans for bugs for R1, R2 and R4's current room prior to May 2025, V8 stated that V8 had forgot that there was one more time a few months ago due to bugs.</p> <p>On 5/21/25 at 12:20 PM, V10 (Housekeeping Aide) stated that V10 is the regular housekeeper on R1, R2, R4 and R7's floor. V10 stated that V10 performed the deep cleaning of R1, R2 and R4's room on 5/13/25 for report of bugs. V10 stated that for the deep clean, all residents have to be out of the room and all of their clothing items removed from the room. V10 stated that all of the furniture is moved to the center of the room; and V10 starts from top to bottom to wipe all surfaces with bleach wipes including bed mattresses, bed frames, furniture (inside drawers too), walls, and floors. V10 stated that floor techs take down the privacy curtains prior to the deep clean to be laundered. V10 stated that V10 performed R1, R2 and R4's room deep clean on 5/13/25 by V10's self. When asked about R1, R2 and R4's privacy curtains being removed prior to V10 performing the deep clean on 5/13/25, V10 stated, Well, I (V10) can't tell you that because I don't do the privacy curtains. V10 stated that the floor techs are the only ones who can get up on the ladder to remove the residents' privacy curtains hanging from the ceiling. V10 stated that V10 does not know if R1, R2 and R4's privacy room curtains were removed on 5/13/25 for the deep clean, by saying, I had everything on. The gown and stuff on my face. I really didn't pay it no attention. I can't remember.</p> <p>Facility documents, each titled Deep Clean Checkoff List, were provided by V8 (Housekeeping Director) on 5/21/25. Upon review of the Deep Clean Checkoff Lists for the month of February 2025, the February 2025 Deep Clean Checkoff Lists were performed on 2/6/25 and 2/28/25 for R2, R4 and R7's room with V10's signature. No deep clean was performed on 2/13/25 or 2/14/25 when R2, R4 and R7's resided in the same room.</p> <p>(continued on next page)</p>		

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  05/22/2025
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.			
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<p>F 0880</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 5/21/25 at 11:10 AM, V11 (NP) stated that V11 is the NP assigned to R2 and is familiar with R2. V11 stated that on 5/12/25, V11 went into the shower room on R1, R2 and R4's floor with nurse on duty, V7 (LPN), and observed body lice crawling on R2's T-shirt around the neck region. V11 stated that the lice were small, light tan and some were a little bit darker. V11 stated that V11 knows that scabies differ from body lice in that scabies show signs of burrowing in the skin, plus they leave little clusters of bites. V11 stated that V11 assessed R2's skin on 5/12/25 and observed bite marks on neck and upper back that matched the areas of the lice noted on R2's T-shirt along with some redness and some raw areas from R2 scratching. V11 stated that V11 ordered for Permethrin cream 5% and Benadryl, ordered Contact precautions, ordered for deep room cleaning and ordered for infectious disease consult. V11 stated that V11 did view V18's progress note after V18 examined R2 on 5/13/25 for R2 having scabies. V11 stated that the medication treatment for lice and scabies must be done congruently with the deep room cleaning for effectiveness. V11 stated that Contact precautions are ordered for prevention of spreading the lice or scabies and must continue for 24 hours post treatment and room cleaning. V11 stated that on 3/10/25, V11 was notified about R2's itchiness and redness to arm by the nurse. V11 stated that V11 assessed R2 on 3/11/25 seeing bite marks to R2's arms and back with redness and scabs. V11 stated that V11 ordered the Permethrin cream again and Benadryl. V11 stated that V11 should have been placed on Contact precautions and that V11 would have given the order for R2's contact precautions. V11 stated that V11 does not manage, evaluate or provide orders for R4 and R7 (R2's roommates on 3/10/25) and that any orders for R4 or R7 for Permethrin cream and Contact precautions would have come from the other providers at that time (3/10/25). V11 stated that V11 expects that the ordered Permethrin cream is administered timely as V11 as ordered. V11 stated that in March 2025, the facility did not have an infection preventionist.</p> <p>On 5/20/25 at 2:08 pm, this surveyor requested to speak with the facility's Infection Preventionist.</p> <p>On 5/20/25 at 3:00 pm, V1 (Administrator) stated that facility does not have an IP nurse and that V2 (DON) was handling it.</p> <p>On 5/21/25 at 3:04 PM, V16 (Infection Preventionist, RN) stated that V16 has been working in the facility as the Infection Preventionist for approximately 4 weeks and is responsible for managing the antibiotic stewardship program, do a deep dive into why residents are placed on isolation precautions, and manage the overall infection control needs for the residents and staff in the facility. V16 stated that there must be a physician's order for isolation precautions which is entered into the resident's EHR. V16 stated for Contact precautions for residents suspected to have lice or scabies, staff are to wear gowns, gloves, hair covers and shoe covers. V16 stated that on 5/12/25, V16 assessed R1, R2 and R4, and Contact precautions was started; V16 stated that V16 observed bugs on R2's skin. V16 stated that V16 performed R1, R2 and R4's isolation assessments and infection criteria evaluations on 5/12/25. This surveyor showed V16 the facility policy for lice, titled IC-Lice/Pediculosis dated January 2023 (review date January 2024). V16 stated for lice, staff members are to discard combs, brushes or communal personal items of residents that could be contaminated. V16 stated that Contact precautions will remain in effect for 24 hours after treatment is completed. V16 stated that nurses will document on the eMAR that Permethrin been administered. V16 stated that if the pharmacy takes time to deliver the Permethrin to the facility, the resident will remain on Contact isolation and all care should o [TRUNCATED]</p>		