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	06/17/2022

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45346 Based on observation, interview, and record review, the facility failed to ensure the Low Air Loss Mattress was not layered with multiple linens and padding's. This failure affected one resident (R4) out of four residents reviewed for pressure ulcers and pressure ulcer prevention interventions. Findings include: On 6/6/22 at 10:30am on the third floor, R4 was observed laying in the supine position with the head of the bed elevated at a 15-degree angle. R4 was laying on a Low Air Loss Mattress wearing an incontinence brief with a four-fold white sheet, pink pad and a bed blanket rolled at the edges. R4's diagnoses include Cerebral Infarction due to unspecified occlusion or stenosis of unspecified cerebral artery, Hemiplegia and Hemiparesis following cerebral infarction affecting left non-dominant side and peripheral vascular disease. R4's (4/13/22) Resident Assessment Instrument documented in part, Section C. Brief Interview for Mental Status (BIMS) score: 15. R4's cognition is moderately intact. R4's (4/13/22) Resident Assessment Instrument documented in part, Section G. A. Bed Mobility- how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture 4/3 coding total dependence / two + persons physical assist. On 6/6/22 at 10:35am V17 (CNA/Certified Nurse Assistant) was notified by the surveyor that R4 had multiple layers of linen on the Low Air Loss Mattress. V17 stated she would notify the CNA for the resident identified as V18 (CNA). On 6/6/22 at 10:40am V18 (CNA) stated, I didn't put this there; this was there from last night. V18 stated there is a four folded white sheet, pink pad, a bed blanket rolled at the edges on top of the air mattress. V18 stated R4 is also wearing an incontinence brief. On 6/6/22 at 12:30pm, again, R4 was still observed laying in the supine position with the head of the bed elevated at a 15-degree angle. R4 was laying on a Low Air Loss Mattress wearing an incontinence brief. with a four-fold white sheet, pink pad and a bed blanket rolled at the edges. (continued on next page)

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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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/6/22 at 12:55pm V7 (Wound Care Coordinator/LPN) stated the facility uses the following pressure ulcer interventions: alternating Low Air Loss Mattress and if the resident is at risk, proper monitoring. V7 stated I(V7) have had a complete in-service with staff on what is supposed to be on the low air loss mattress. R4's care plan dated 5/27/22 states R4 is at risk for skin breakdown related to incontinence, impaired mobility and comorbidities. R4's intervention includes use of a pressure redistribution mattress in place for pressure relief. R4's care plan dated 5/27/22 documents, in part, the focus, R4 has an ADL self-care performance deficit. Interventions include but are not limited to, bed mobility: R4 requires extensive assistance times 1-2 staff participation to reposition and turn in bed. R4's Pressure Ulcer Risk assessment dated [DATE] shows that R4 scored 13 on the scale (moderate risk for pressure ulcer development). Facility's policy titled Skin Management: Specialty Mattress dated 7/10 (last reviewed date of 3/22) states in Procedure #1: Limit the amount of linen placed between the support surface and the resident.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32338 Based on observation, interview, and record review, the facility failed to supervise a resident who had a history of falls to prevent repeated falls; and failed to implement individualized progressive fall prevention interventions for a resident who was identified to be at risk for falls. These failures affected one resident (R2), out of 2 residents, reviewed for falls. R2 fell three times within two weeks and had a fourth fall with injury to the head and face, that required hospitalization , with a diagnosis of Closed Head Injury and Fall. Findings include: R2's hospital records dated 5/19/2022, page 13, under Diagnosis and Plan/Problem List, written by V20 (Hospital Physician) states: #1. Close Head Injury; #2. Fall. In addition, page 16 shows that R2 had Traumatic Ecchymosis of Face and Facial Laceration. Page 12, under Diagnosis and Plan shows that R2's hospital admitting diagnoses were Closed Head Injury and Fall. On 6/6/22 at 10:45am, the facility's reported incident that was sent to state agency was reviewed. The final report dated 5/26/22 shows that R2 was found on the floor with two hematomas and a laceration above the left eye. This report also shows that was in the hospital from 5/19/22 to 5/23/22. R2's admission diagnoses include but are not limited to Hypertension, Diabetes, Schizoaffective Disorder, Anemia, Anxiety, Depression, Syncope and Collapse, Hypoglycemia, Dementia, and History of Falling. On 6/6/22 at 10:40am during observation of residents on the fourth floor, R2 was observed in the wheelchair several times moving around in hallway unsupervised, far away from the nursing station, and not within view of any staff member. Facility's Falls Incident Reports presented by V3(Restorative Nurse) shows that R2 recently had falls as follows: Dated 1/7/22; Location: Resident's room; Nursing Description; resident was noted sitting on her buttock by her bed on the floor. Dated 1/9/22; Location: Resident's Room; Nursing Description; CNA (Certified Nursing Assistant) informed writer that resident was on the floor; writer observed resident lying on her left side on floor next to bed. Dated 1/20/22; Location: Resident's Room; Nursing Description; Resident was observed on the floor with bleeding noted to the right side of her forehead. Dated 5/19/22; Location: Resident's Room; Sent to emergency room . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R2's Fall care plan dated 11/09/2019 documents in part - Focus: Resident is unable to use call light due to cognitive status. Interventions: Resident will be evaluated for specific safety alert device. R2's Fall Risk Screen dated 5/23/22, documents in part, Category: Moderate Risk. 3. History of Falls within last six months, 5. Multiple Falls. R2's Minimum Data Set (MDS), dated [DATE], documents that R2 has a Brief Interview for Mental Status (BIMS) score of 6 out of 15, which indicates that R2 has severe impairment. Section G. Functional Status: Bed Mobility, Transfer, Locomotion on unit, requires extensive assistance. On 6/7/22 at 1:07pm, V8 (Social Worker) was interviewed regarding R2's fall that resulted in hospitalization . V8 stated that V8 was walking down the hall and heard someone yelling for help and went into R2's room and saw that R2 was on the floor. V8 explained that V8 ran to get the nurse and we both came into the room and assisted (R2) to the wheelchair. On 6/7/22 at 12:00pm, V4 (License Practical Nurse, LPN) was interviewed regarding R2's fall. V4 stated that the social worker (V8) notified V4 that R2 was on the floor. V4 stated that R2 was lying face down on the floor when V4 came into the room. V4 explained that V4 assessed R2 before moving R2 off the floor. V4 added that the social worker helped V4 get R2 up off the floor. V4 explained that R2 had a mark on R2's head and a laceration on the left side of R2's face. V4 added that the Nurse Practitioner came to the floor to do an assessment and ordered to send R2 to out for an evaluation. On 6/7/22 at 1:45pm, V10 (Nurse Practitioner, NP) was interviewed regarding R2's several falls and her professional opinion about preventing repeated falls. V10 stated that V10 was aware of previous falls of R2. Regarding the fall on 5/19/22, V10 stated that V10 assessed R2 and observed a hematoma above R2's left eye. V10 explained that when V10 was asking R2 questions, R2 would not answer any questions. V10 added that V10 sent R2 to hospital for evaluation. The Surveyor inquired from V10 about the Interventions dated 11/9/2019 on R2's care plan to evaluate resident for specific safety alert device. V10 stated, I do not know what device they are talking about. V10 stated that she (V10) will follow up on it and get back with the surveyor. V10 did not get back to the Surveyor. On 6/7/22 at 2:08pm, V19(Care Plan Nurse) was interviewed about R2's care plan. V19 stated that R2 cannot use call light because of R2's cognition. The Surveyor Inquired from V19 about the intervention in R2's care plan regarding resident being evaluated for specific safety alert device. V19 responded, That's not supposed to be there, that's wrong. V19 stated that R2 needs to be closer to the nursing station. R2's Progress Notes dated (5/19/22) at 3:17pm written by V4 (LPN) states: Writer notified by the social worker that the resident was in the room on the floor next to the bed. After lifting the resident back to the bed, noted a hematoma x 2 and a laceration above the left eye with minimal drainage. Completed head to toe assessment. BP (Blood Pressure) 125/74, P(Pulse) 72, 02(Oxygen) 96% RR (Respiration Rate) 20. NP (Nurse Practitioner) and PCP (Primary Care Physician) notified. Unable to reach her daughter POA (Power of Attorney). NP spoke with the son on POC (Plan of Care). Ambulance has been called to transport resident to Local Hospital ED (Emergency Department) for CT (Cat Scan) of head. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Facility's Policy with review date 6/21 and titled, Falls Management, documents, in part, under General: The facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe and environment as possible. All resident falls shall be reviewed, and the resident's existing plan of care shall be evaluated and modified as needed.