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	09/21/2022

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 30279 Based on observation, interview and record review the facility failed to ensure resident call light was within reach for 11 of 11 residents (R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, and R18). Findings include: On 08/24/22 between 10:27am to 12:00pm, the following observations were made regarding call light not placed within reach of the resident: At 10:34am, R8 was noted in bed with the call light noted on the floor not within reach. R8's MDS (Minimum Data Set) assessment tool dated July 18, 2022, showed that R8 has a BIMS (Brief Interview for Mental Status) of 13. R9 was noted in bed with the call light noted on the floor not within reach. R9's MDS (Minimum Data Set) assessment tool dated August 18, 2022, showed that R9 has a BIMS (Brief Interview for Mental Status) of 08. R10 was noted in bed with the call light noted on the floor behind the headboard not within reach. R10's MDS (Minimum Data Set) assessment tool dated July 3, 2022, showed that R10 has a BIMS (Brief Interview for Mental Status) of 12. R11 was noted in bed with the call light noted on the floor not within reach. R11's MDS (Minimum Data Set) assessment tool dated July 26, 2022, showed that R11 has a BIMS (Brief Interview for Mental Status) of 08. R12 was noted in bed with the call light noted on the floor not within reach. R12's MDS (Minimum Data Set) assessment tool dated July 1, 2022, showed that R12 has a BIMS (Brief Interview for Mental Status) of 10. R13 was noted in bed with the call light noted on the floor not within reach. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R13's MDS (Minimum Data Set) assessment tool dated July 31, 2022, showed that R13 has a BIMS (Brief Interview for Mental Status) of 15. R14 was noted in bed with the call light noted on the floor not within reach. R14's MDS (Minimum Data Set) assessment tool dated July 6, 2022, showed that R14 has a BIMS (Brief Interview for Mental Status) of 12. R15 was noted in bed with the call light noted on the floor not within reach. R15's MDS (Minimum Data Set) assessment tool dated July 1, 2022, showed that R15 has a BIMS (Brief Interview for Mental Status) of 15. R16 was noted in bed with the call light noted on the floor not within reach. R16's MDS (Minimum Data Set) assessment tool dated August 25, 2022, showed that R16 has a BIMS (Brief Interview for Mental Status) of 09. R17 was noted in bed with the call light noted on the floor not within reach. R17's MDS (Minimum Data Set) assessment tool dated August 15, 2022, showed that R17 has a BIMS (Brief Interview for Mental Status) of 09. R18 was noted in bed with the call light noted on the floor not within reach. R18's MDS (Minimum Data Set) assessment tool dated June 12, 2022, showed that R18 has a BIMS (Brief Interview for Mental Status) of 12. On 08/24/22 at 10:41am, interview with V8 CNA (Certified Nurse's Aide) regarding call light, V8 stated call light should be where they (referring to residents) can reach it (Call Light). On 08/24/22 at 10 50am, interview with V9 (CNA)regarding call light placement, V9 stated call light should be placed within resident reach. On 08/24/22 at 11:40am, interview conducted with V13 LPN (Licensed Practical Nurse) regarding call light. V13 stated call light should be attached to the pillow or the resident linen on the bed and within reach of the resident. On 08/24/22 at 3:31pm, interview with V2 DON (Director of Nursing) regarding call light placement. V2 stated that if resident is in the room, call light should be placed within residents' reach. The facility policy on Call Light Answering with created date 10.2021 documented that the policy is to provide the staff with guidance on responding to resident's request and needs. The procedure includes but not limited to when the resident or resident is in bed or confined to bed or chair, provide the call light within easy reach of the patient or resident.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 30279 Based on observation, interview and record review, the facility failed to provide personal privacy for one resident (R6) during blood glucose monitoring. This failure affected R6 whose blood glucose was obtained in front of the nurse's station with peers and visitors present and has the potential to affect 38 residents identified as receiving blood glucose monitoring. Findings include: On 08/30/22 at 12:30pm, R6 was sitting in a wheelchair at the nurse's station on the 3rd floor and asked V10 LPN (Licensed Practical Nurse) for her (R6's) glucose monitoring to be done. V10 told R6 to go and eat stating that her (R6's) blood sugar was fine. R6 stated, my (R6) glucose monitoring has not been done. V10 proceeded to take R6's blood glucose in view of other residents and visitors at the nurse's station despite V12 (LPN) asking V10 to take R6 to her (R6's) room for privacy. V10 continued to ignore V12's request. On 8/30/2022 at 12:56pm, surveyor asked V10 the facility's privacy policy when performing blood glucose monitoring on a resident. V10 stated, Monitoring (referring to performing blood glucose) should be done in privacy in the resident's room. The Residents' Right booklet for People in Long-term Care Facilities presented documented in part under Privacy that resident's medical and personal care are private. This guideline was not followed.

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30279 Based on interview and record review, the facility failed to keep one resident (R5) free from physical abuse. This failure affected one of three residents (R5) reviewed for physical abuse that sustained injury/wounds to both knees, swelling and redness of left eye and a small scratch under left eye. This failure has the potential to affect all 180 residents residing in the facility. Findings include: R4's medical record showed that R4 was admitted to the facility initially 11/18/2021. Last admitted was 08/22/22. R4's listed diagnosis includes but not limited to other specified Abnormal Immunological findings in serum, Alcohol Abuse Uncomplicated, Nicotine dependence, cigarettes uncomplicated, Other Psychoactive Substance Abuse in remission, and Major Depressive Disorder Recurrent, mild, Opioid Dependence uncomplicated, and Opioid use unspecified, uncomplicated. R4's Minimum Data Set (MDS) dated [DATE], Section C-brief interview for mental status summary score is (06) indicating R4 is cognitively impaired. R5's medical record documented that R5 was last admitted [DATE]. Diagnosis list includes but not limited to Epileptic Seizures related to external causes not intractable without status Epilepticus, Unilateral primary Osteoarthritis Left Knee, Alcohol Abuse, Effusion Left Knee, Acute Embolism and Thrombosis of Right Femoral Vein, Other Chondrocalcinosis Right Knee. R5's Minimum Data Set (MDS) dated [DATE], Section C-brief interview for mental status summary score is (11) indicating R5 is moderately impaired. R5's medical record progress notes and POS (Physician Order Sheet) showed the following documentation: 1.Review of R5's progress noted documentation dated 08/15/22 timed 22:43 (10:43pm) V12 LPN (Licensed Practical Nurse) documented in part that R4 struck peer (referring to R5) several times in the face. R4 was assessed and marks were noted to left elbow. 2.V16 documented on 08/15/22 that the reason for report was due to Aggressive and threatening behavior towards other specific resident escalated when (R4) started to get physically aggressive. At 2130-2140 (9:30pm-9:40pm) R4 came up to another resident and started to punch repeatedly and pull (R5) off the wheelchair. 3.V26 LPN (Licensed Practical Nurse) for R5 on the day of incident documented that writer was informed by staff that resident (R5) had a physical altercation with peer (R4) on the courtyard. Resident (R5) was immediately separated and placed on 1:1. Resident (R5) was assessed by writer(V26) upon entering the courtyard. Writer (V26) noted swelling to the left eye and a small scratch under left eye. Left eye is red. No other bruise noted. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	4.V20's documentation in R5's progress note dated 08/16/22 timed 8:50am documented that this writer did body assessment this morning on resident. Resident (R5) only noted to have sores on both knees no other injury noted. 5. V4 (wound care Nurse) documented that on 08/17/22 at 1:07pm that R5 had a skin tear to left and right knee with wound care department will be monitoring. According to facility investigation reviewed, V1 (Administrator) documented on 8/18/2022 in part that V24 (Security guard) heard the yelling and when V24 approached, V24 immediately intervened and called for backup. V24 did not observe any physical contact between R4 and R5. V1 documented that based on known facts, the following conclusions have been determined that the allegation of physical abuse is unsubstantiated because R4 did not have any physical contact with R5. On 08/24/22 at 3:14pm, interview conducted with V1 regarding the facility investigation of physical abuse on 8/15/2022. V1 stated R1 was a witnessed to an abuse situation and R1 was not abused but saw the altercation between R4 and R5. R1 medical record documents admitted [DATE]. R1's diagnosis includes but not limited to Obesity, unspecified, Type 2 Diabetes Mellitus with Hyperglycemia, Essential Hypertension R1's Minimum Data Set (MDS) dated [DATE], Section C-brief interview for mental status summary score is (14) indicating R1 is cognitively intact. On 08/24/22 at 4:27pm, R1 was asked regarding the incident R1 witnessed between R4 and R5 on 8/15/2022. R1 explained that some of the residents were on the patio (Smoking Area) smoking. R1 stated, I (R1) witnessed R4 and R5 arguing and R4 started hitting R5 in the head, face and (R4) threw (R5) on the floor from the wheelchair. R1 stated, R4 continued to hit R5 while on the floor. R1 stated, There was no staff around at the time, so I (R1) had to call other residents that were present to assist me (R1) in separating R4 and R5 while one resident was yelling for the staff. R1 stated, By the time the staff showed up, R5 was on the floor bruised on the knees, face punched and swollen. On 08/25/22 at 12:12pm, interview with R5 regarding the physical altercation with R4. R5 stated that someone (referring to R4) turned me over from my wheelchair and I (R5) fell and hurt my legs. R5 touching the face and forehead said (R4) hit me in my face my head and knock me on the floor. At 12:17pm R5 pulled his pants leg up and showed the surveyor his bilateral knees with V20 LPN (Licensed Practical nurse) present at the time. Surveyor observed dressings on both knees of R5. V20 then told the surveyor that (R5) was in an altercation with another resident (referring to R4) and was thrown on the floor from his wheelchair and R5 got injured on both knees. When V20 tried to touch the left knee R5 clinched and stated it hurts. R5 showed facial grimaces that reflect pain and told the surveyors that it is not fair for (R4) to hit me like that. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 08/25/22 at 12:25pm, interview conducted with R4 regarding physical altercation with R5. R4 stated that, I (R4) was sitting there on the patio talking. R4 stated, He (R5) came over there, and things don't look right anymore, no one hits me and gets away. R4 stated, R5 picked up this big plastic yellow cone (referring sign used by housekeeping) so I blocked him (R5), and I lost my temper when R5 hit me. R4 stated, I (R4) really did not hit him as hard as I could, but I gave him one on his mouth and I threw him out of the wheelchair. (R5) was in a wheelchair which doesn't matter to me. I (R4) then see paramedics and they said the police is coming and I (R4) should follow them to the hospital. They (referring to paramedics) said they will bring me back after seeing the doctor. R4 stated, they (paramedics) said they will strap me (R4) up if I (R4) don't follow them. On 08/25/22 at 2:51pm, V4 (wound care Nurse) presented R5's bilateral knee wound care assessment dated [DATE] timed 1:07pm. V4 documented in part that he (V4) was notified by the floor nurse of a possible wound on (R5) Legs. Upon assessment noted skin tear to (R5) left and right knee. V4 stated the knees were not done until 08/17/22 because the wound care department was not notified until 08/17/22. Left knee Measurement 1.00cm (Centimeter) in length, 0.80cm width and 0.10cm in depth. Right knee Measurement 2. 00cm length x 2.00cm width x 0.10cm depth. R5's treatment order dated 8/17/2022 showed orders for right knee to Cleanse with NSS (Normal Saline Solution) or wound cleanser, pat dry, skin prep peri wound, apply xeroform, and cover with a dry dressing 3x week / PRN (As needed) every day shift every Mon, Wed, Fri for To Promote Wound Healing and as needed for To Promote Wound Healing. Left knee order read to cleanse with NSS or wound cleanser, pat dry, skin prep peri wound, apply xeroform, and cover with a dry dressing 3x week / PRN every day shift every Mon, Wed, Fri for To Promote Wound Healing On 08/30/22 at 12:21pm, R6 was in her room in a wheelchair. Surveyor asked R6 regarding the 08/15/22 physical altercation between R4 and R5. R6 stated, R4 was the aggressive one and he hit R5 in the head and kicked R5 while R5 was lying on the floor. R6's Minimum Data Set (MDS) dated [DATE], Section C-brief interview for mental status summary score is (15) indicating R6 is cognitively intact. On 08/30/22 at 12:24pm, interview conducted with R7 regarding the physical altercation between R4 and R5. R7 stated, The residents were on the smoking patio smoking when R4 attacked R5. R4 was hitting R5 and throwing R5 out of the wheelchair to the floor. R7 stated, R4 was kicking R5 on the head and the body and because the staff was not around the other resident had to hold R4 away from R5. R7 stated, There was no security guard at the time so one of the residents had to run and called the security staff. R7's Minimum Data Set (MDS) dated [DATE], Section C-brief interview for mental status summary score is (12) indicating R7 is mildly impaired. During this investigation calls were placed to V16 (RN), V24 (Security Guard), and V26 (LPN) with no return phone call. The facility Abuse Prevention Program policy presented documented in part that residents have the right to be free from abuse and this includes but not limited to any physical abuse. The purpose of this policy and abuse program is to describe the process for identification, assessment, and protection of residents from abuse, to be accomplished by establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Abuse is defined in part as a willful infliction of injury or punishment that which resulted in physical harm. Physical abuse is defined as infliction of injury on a resident other than by accidental means. Physical abuse includes but not limited to hitting, slapping and kicking. The term willful in the definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 30279 Based upon record review and interview the facility failed to report an injury to IDPH (Illinois Department of Public Health) within regulatory requirements for one of three residents (R2) reviewed for fall with injury. This failure affected R2 who had a fall with a suspicious injury. This has the potential to affect all 180 residents residing in the facility. Findings include: On 08/24/22 at 4:02pm, V2 DON (Director of Nurses') was asked if R2's fall was witnessed or unwitnessed. V2 stated, I (V2) assumed since V26 who worked on that day documented that she heard a noise I (V2) believed that it was a witnessed fall. V2 stated, we (referring to the facility) did not get any report from the hospital originally. R2 went to one community hospital and was transferred to another community hospital for repeat of CT. V2 was asked if anyone at the facility followed up on whether R2 had an injury and if the injury was reported according to the regulation and facility policy. V2 stated, there has not been a report on R2 since R2 left the facility, so I (V2) am not aware of R2 having any injury. R2's medical record progress note dated 07/14/2022 timed 5:26pm showed V26 (LPN) documentation as follows: 07/14/2022 17:26 Health Status/Progress Note Text: Writer observed resident in dining room and heard a noise. Writer seen resident on her left side laying on the floor. Writer assessed resident and noted open area to the left side with minor bleeding. V/S taken B/P 114/69, RR 18, pulse 73, T 98.0, SPO 98 RA. Writer and CNA help resident back in chair. Resident voiced no pain. Writer asked how you fall resident stated, I was trying to get my shoes. Daughter in the building she made aware. MD called awaiting on call back. R2's emergency room medical record documented in part on 07/14/22 imaging reviewed CT neck showing concern for cord compression at this time, given imaging results-recommend need for emergent MRI to rule out cord compression at this time. Patient (R2) require escalation of care. R2 had 3cm (Centimeter) superficial laceration to left eye with bleeding controlled. Dermabond (Skin Adhesive) shut with approximation of laceration. Diagnostic test result CT (Computer Tomography) Spine Cervical w/o contrast dated 07/14/22 at 8:48pm (20:48) documented under impression that C1/C2/basion findings as described suspicious for complex ligamentous injury and potential cord compression. Question age-indeterminate atlantoaxial/rotatory subluxation and even low-grade occipital-axial dissociation. Recommend MRI and comparison to priors. During the course of this survey, the facility did not submit an initial or final report related to the injury R2 sustained at the facility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy presented Falls Management documented in part that following a fall a complete fall event will be done and this will include but not limited to the circumstances surrounding the fall, devices in use, full body observation for injury, all incident and accident with serious physical injury will be initiated reported as required to the State Agency. A final written investigation report is required by the State Agency within seven days of the incident.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30279 Based on interview and record review the facility failed to conduct a thorough investigation for three of three residents (R2, R4, and R5) reviewed for injury and abuse in the sample. Findings include: R2's medical record documented admission as 06/29/22, with diagnosis information that includes but not limited to unspecified Dementia without behavioral disturbances, Displaced fracture of Proximal phalanx of the left index finger, subsequent encounter for fracture and routine healing, Pain Left hand, presence of unspecified Artificial Knee Joint, Vascular Dementia without behavioral disturbance, Primary Generalized (Osteo) Arthritis, Heart Failure and Unilateral primary osteoarthritis, right knee. R2's Minimum Data Set (MDS) dated [DATE], Section C-brief interview for mental status summary score is (00) indicating R2 is severely impaired. R2's medical record showed R2 had a fall on 07/14/22 and was sent to a local community hospital for further evaluation and treatment. R2 was then transferred to another community hospital for further evaluation and treatment. R2's progress note dated 7/14/2022 at 17:26 (5:26pm) Health Status/Progress Note Text: Writer observed resident in dining room and heard a noise. Writer seen resident on her left side laying on the floor. Writer assessed resident and noted open area to the left side with minor bleeding. V/S taken B/P 114/69, RR 18, pulse 73, T 98.0, SPO 98 RA. Writer and CNA help resident back in chair. Resident voiced no pain. Writer asked how you fell resident stated, I was trying to get my shoes. Daughter in the building she made aware. MD called awaiting on call back. R2's emergency hospital record showed R2 was admitted on [DATE]. The report documented that R2 fell at the facility, had a 3cm (Three centimeter) superficial laceration on the left eyebrow used Dermabond on the area and there was no more bleeding at the site. Under reexamination/reevaluation imaging reviewed CT head showing no acute intracranial processes. CT neck showing concerns for cord compression currently. Given imaging result recommend need for emergent MRI to rule out cord compression at this time. Patient (referring to R2) will require escalation of care, spoke with (another hospital trauma center) who accepted patient (R2). Superficial laceration Dermabond shut with approximation of laceration. On 08/24/2022 at approximately 4:07pm surveyor asked V2 if an investigation was done regarding R2's fall on 7/14/2022. V2 stated, No, because there was no report of injury from the hospital. R4's medical record showed that R4 was admitted to the facility initially 11/18/2021. Last admitted was 08/22/22. R4's listed diagnosis includes but not limited to other specified Abnormal Immunological findings in serum, Alcohol Abuse Uncomplicated, Nicotine dependence, cigarettes uncomplicated, Other Psychoactive Substance Abuse in remission, and Major Depressive Disorder Recurrent, mild, Opioid Dependence uncomplicated, and Opioid use unspecified, uncomplicated. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's Minimum Data Set (MDS) dated [DATE], Section C-brief interview for mental status summary score is (06) indicating R4 is cognitively impaired. R5's medical record documented that R5 was last admitted [DATE]. Diagnosis list includes but not limited to Epileptic Seizures related to external causes not intractable without status Epilepticus, Unilateral primary Osteoarthritis Left Knee, Alcohol Abuse, Effusion Left Knee, Acute Embolism and Thrombosis of Right Femoral Vein, Other Chondrocalcinosis Right Knee. R5's Minimum Data Set (MDS) dated [DATE], Section C-brief interview for mental status summary score is (11) indicating R5 is cognitively impaired. Review of R5's medical record progress notes showed the following documentation: V16 documented on 8/15/2022 between 2130 and 2140 (9:30pm and 9:45pm) R4 started to get physically aggressive and came up to another resident and started to punch repeatedly and pull R5 of the wheelchair. V26 LPN (Licensed Practical Nurse) documented at 2210 (10:10pm) in part R5 had a physical altercation with peer (R4) on the courtyard. Resident (R5) was immediately separated and placed on 1:1. Resident (R5) was assessed by writer (V26) upon entering the courtyard. Writer (V26) noted swelling to the left eye and a small scratch under left eye. Left eye is red. No other bruise noted. V12 (LPN) documentation on 08/15/22 timed 22:43 (11:43pm) V12 LPN (Licensed Practical Nurse) documented in part that R4 struck peers struck peer (referring to R5) several times in the face. R4 was assessed and marks were noted to left elbow. V20's documentation in R5's progress note dated 08/16/22 timed 8:50am documented that this writer did body assessment this morning on resident. Resident (R5) only noted to have sores on both knees no other injury noted. V4 (Wound Care Nurse) documented that on 08/17/22 at 1:07pm that R5 had a skin tear to left and right knee with wound care department will be monitoring. According to facility investigation, V1 (Administrator) documented in part that V24 (Security guard) heard the yelling and when V24 approached he saw the altercation but did not witness R4 hitting R5. V1 documented that based on known facts, the following conclusions have been determined that the allegation of physical abuse is unsubstantiated because R4 did not have any physical contact with R5. (continued on next page)

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	145661	A. Building B. Wing	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ryze West	5130 West Jackson Boulevard Chicago, IL 60644

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Abuse Prevention Program policy presented documented in part VII. 5. Investigation Procedures. The appointed investigator will attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident. Any written statements that have been submitted will be reviewed, along with any pertinent medical records or other documents. 9. Final Investigation Report. The investigator will report the conclusions of the investigation in writing to the administrator or designee. The final written report of the results of the investigation will be forwarded to the Illinois Department of Public Health. The final investigation report shall contain the following: Facts determined during the process of the investigation, review of the medical record and interview of the witnesses; Conclusion of the investigation based on known facts.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30279 Based on observation, interview and record review, the facility failed provide care and services for the management of a resident's diabetes by not following physician orders to administer insulin medication as ordered, failed to document insulin administration and glucose level, and failed to have staff knowledgeable about the use of an insulin pen. These failures affected 1 of 38 residents (R6) diagnosed with diabetic mellitus receiving insulin. As a result of this failure R6 was administered 300 units of insulin and R6's blood sugar measured 205 mg/dl when insulin was administered. This facility failure has the potential for R6 experiencing adverse effects and complications of unstable blood sugar including but not limited to: Diabetic ketoacidosis, Hypoglycemia and Hyperglycemia. This was identified as an immediate jeopardy which began on 8/30/2022 when surveyor observed V10 (LPN) drawing up the incorrect dosage of insulin with an insulin syringe from the insulin pen and administering to R1. The immediacy was removed on 09/06/2022. V1 (Administrator) was informed of the immediate jeopardy and the immediate jeopardy template was presented on 09/01/22 at 3:29pm. The facility provided an initial removal plan on 09/2/2022 and was not accepted on 09/02/2022. The facility presented a modified removal plan on 09/08/2022 and the plan was accepted on 09/08/2022. Although the immediacy was removed, the deficiency remains at the second level of harm until the facility can determine the effectiveness of the implementation of removal plan. Findings include: R6's medical record showed that R6 was admitted to the facility originally on 06/08/2020 and initial admission of 03/15/2021. Diagnosis includes but not limited to: Type 2 Diabetes Mellitus with Hyperglycemia, Type 2 Diabetes Mellitus with Diabetic Neuropathy unspecified, other seizures, Shortness of breath, Acute bronchitis, Wheezing, Chest pain, other visual disturbances, Acute Embolism and Thrombosis of unspecified Deep Veins of Right Lower Extremity. R6's Minimum Data Set (MDS) dated [DATE], Section C-brief interview for mental status summary score is (15) indicating R6 is cognitively intact. R6's Diabetes Mellitus plan of care with initiated date of 03/28/2021 documented interventions include but not limited to blood glucose monitoring per MD (Medical Doctor) order and document. Diabetes medication as ordered by doctor. Monitor /document for side effects and effectiveness. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/30/22 at 12:30 p.m. on the 3rd floor, surveyor observed R6 sitting in a wheelchair at the nurse's station asking for V10 (LPN) to check her (R6) glucose level. V10 LPN told R6 to go and eat and that R6's blood sugar was fine. R6 stated, my (R6) glucose monitoring has not been done. V10 proceeded to obtain R6's blood glucose in view of other residents and visitors at the nurse's station despite V12 (LPN) asking V10 to take R6 to R6's room for privacy. R6's blood glucose measured 205mg/dl. V10 went to the medication cart and obtained R6's insulin pen. V10 then came back to the medication cart and obtained an insulin syringe. V10 opened the insulin syringe and inserted the insulin syringe (U100) needle into the rubber stopper of the insulin pen and withdrew insulin from the insulin pen into the insulin syringe. As V10 prepared to administer R6 the insulin at the nurses' station, V5 (SSD) came and assisted R6 to her (R6's) room and stated to V10, Medication administration should be done in the resident's room for privacy. Upon R6 returning to (R6's) room, the surveyor observed V10 preparing to administer the insulin in R6's abdomen. Prior to V10 administering the insulin to R6, the surveyor intervened and asked V10 to clarify the dose of insulin in the syringe. V10 stated, 60 units of Humulin R. V10 showed the surveyor the syringe. The surveyor observed the insulin syringe at the 60 units measurement mark. Again, the surveyor asked V10 to clarify the amount (dose) of insulin that was supposed to be administered with the medication order since the surveyor did not observe V10 verify the physician order with the EMAR prior to preparing the insulin for administration. V10 stated, I know the order. R6 is supposed to get 120 units but I'm given (R6) 60 units half of what is ordered. The surveyor asked V10 why she (V10) was giving R6 half of the dose of insulin ordered by the physician. V10 replied, Personally, I don't believe R6 should be getting that much (referring to ordered insulin), so I (V10) am giving half of the dose. The surveyor asked V10 why she (V10) withdrew the insulin from the insulin pen using an insulin syringe. V10 stated, I (V10) don't usually like the pen (referring to the insulin pen) because the insulin is usually stronger when it's used with the pen. The surveyor immediately asked V10 to stop the insulin administration and to clarify the physician order. V10 disregarded the surveyor's request and administered the insulin to R6 using the insulin syringe with the measured amount of 60 units observed on the insulin syringe. After V10 administered the insulin to R6, V10 stated to the surveyor, I (V10) know the order. On 8/30/2022 at 12:56pm, V10 and the surveyor checked the EMAR (electronic medication administration record) and the POS (physician's order sheet) for R6's insulin order. R6's POS dated 1/22/2022 showed an order of Humulin R U-500 K*** Pen Solution Pen-injector 500 UNIT/ML (Insulin Regular Human (Conc) to Inject 140 unit subcutaneously in the morning related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA (E11.65) With breakfast AND Inject 140 unit subcutaneously in the afternoon related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA (E11.65) With lunch AND Inject 125 unit subcutaneously in the evening related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA (E11.65) With dinner. There was no physician order to inject 60 units of insulin to R6. The order showed that R6 should have received 140 units of insulin Humulin R via insulin pen (Pen-injector). (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/30/2022 at approximately 12:59pm, surveyor asked V10 about the facility protocol regarding insulin administration and withdrawing insulin from the insulin pen. V10 replied, You (referring to surveyor) want the book knowledge form or what I (V10) do in real world. V10 stated, I don't think using the pen hits the same or works well for (R6) and I'm trying to study (R6) to see what works well for (R6) so that's why. The surveyor further asked V10, what is the facility policy on medication administration regarding physician orders, notification of physician and clarification of medication orders. V10 stated, The physician order should be carried out and medication pass should be passed one hour before and one hour after. Medication should be given as ordered by the physician. Surveyor asked V10 if she (V10) administrated R6's insulin medication as ordered. V10 replied, No because I'm (V10) still trying to get the coverage (referring to insulin) and let the physician know about it. During this time, the surveyor did not observe V10 notify the MD of the medication error nor did V10 document notification of the medication error at the time the error was made. V10 was aware she did not administer R6 the ordered dose of insulin. On 8/30/2022 at approximately 1:03pm, V2 DON (Director of Nurse's) walked out of the elevator and overheard V10 explaining V10's actions regarding insulin administration to surveyor. V2 stated to surveyor, I can't believe the explanation of whatever question you asked her (referring to V10). On 08/30/22 at 2:02pm V2 (DON) stated, medication is to be given as physician ordered, if it says (referring to the order) insulin pen it should be given via insulin pen. Surveyor asked V2 can the nurses change a physician order. V2 stated, They (referring to nurses) are not physicians so they cannot change the order. All orders are to be given as physician ordered. On 8/30/22 at 2:13pm Surveyor asked V2, what can happen to residents if medication (referring to insulin) is not administered as prescribed. V2 stated, It means the resident can go into Hypo or Hyperglycemic reaction depending on what is going on with them (referring to resident). On 08/30/22 at 4:00pm the facility was unable to present any documentation that showed V10 informed R6's physician of the insulin medication error. MAR dated 8/30/2022 at 1730 (5:30pm) R6's BS (blood sugar) documented 182. On 09/01/22 at 11:55am, surveyor conducted interview with V25 NP (Nurse Practitioner) regarding the significance of following the physician order for insulin administration for R6. V25 stated, R6 is non-compliant with her (R6's) diet and if the insulin is not given as ordered she (R6) may possibly have hyperglycemic or hypoglycemic episodes. On 09/03/22 at 10:12am, interview with V27 (Pharmacist) regarding the amount of insulin administered to R6, and the use of an insulin syringe instead of the insulin pen. V27 stated that the amount of insulin administered to R6 via an insulin syringe equals 300 units and that is 160 units more than the 140 units ordered. V27 stated, the amount in the pen is of a large concentration 500 units/ml (Milliliters), and the way the nurse used the insulin pen defeats the purpose of how the pen was designed to be used. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facility Charge Nurse Job Description dated 2003 in part states: Purpose of Your Job Position - The primary purpose of your job position is to provide direct nursing care to the residents. Such supervision must be in accordance with current federal, state, and local standards, guidelines and regulations that govern our facility to ensure that the highest degree of quality care is maintained at all times. Delegation of Authority - As Charge Nurse you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties. Duties and Responsibilities - Ensure all nursing personnel assigned to you comply with the written policies and procedures established by this facility. Periodically review department's policies, procedure manuals. Ensure that all nursing service personnel comply with the procedures set forth in the Nursing Service Procedures Manual. Perform administrative duties such as completing medical forms, reports, evaluations, studies, charting etc., as necessary. Chart nurses' notes in an informative and descriptive manner that reflects the care provided to the resident as well as the resident's response to the care. Perform routine charting duties as required and in accordance with established charting and documentation policies and procedures. Prepare and administer medications as ordered by the physician. Consult with the resident's physician in providing the resident's care, etc. as necessary. Review the resident's chart for specific medication orders, etc. as necessary. Facility policy regarding Insulin Pen Usage dated 06/2021 documented in part, the policy is to provide the staff with guidance on accuracy of insulin administration and dosing. Listed responsible party are RN (Registered Nurse) or LPN (Licensed Practical Nurse). Policy statements includes but not limited to never use syringe to draw insulin out of an insulin pen cartridge. Administer insulin as ordered. Listed procedure includes but not limited to documenting each insulin dosage, site, time, in the EMAR (Electronic Medication Administration Record). The facility Medication administration policy presented with review date 11/2021 documented in part: all medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis. Listed responsible party are RN (Registered Nurse) or LPN (Licensed Practical Nurse). Listed guideline includes but not limited to an order is required for administration of all medication. Checking medication administration record prior to administering medication for rights that includes the dose. Following special instruction written on the label. Document as each medication is prepared in the MAR (Medication Administration Record). If medication is not given as ordered, document the reason on the MAR and notify the Health Care Provider and resident representative if applicable. Facility presented the manufacture's undated Instructions for the use of the Humulin R U-500 K***Pen which included the following: Important: Know your dose of Humulin R U-500 insulin. The pen delivers your dose in insulin units. Insulin units may not be the same as syringe markings. Your Humulin R U-500 is a concentrated insulin. Do not transfer Humulin R U-500 insulin from Pen into a syringe. A severe overdose can happen, causing very low blood sugar, which may put your life in danger. Based on the evidence the facility did not follow established policies and the manufacturer's instructions for the use of an insulin pen. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The surveyor on 09/12/2022 via observation, interview and record review confirmed the following removal plan was implemented by the facility: 1. R6 and POA (Power of Attorney) were notified of R6 receiving incorrect dose of Insulin. 2. R6, NP (Nurse Practitioner) and POA were notified that insulin from the U500 insulin pen was administered with a U100 Insulin syringe rather than the insulin pen as ordered. 3. Follow up blood glucose of 188 4. All resident with insulin administration and blood glucose monitoring reviewed for compliance to assure no other resident is affected. 5. Facility nurses were being educated on: Facility policy regarding medication administration including the rights of medication administration including correct dose, time, patient, medication and route as well as notifying the physician or NP when error occurs. Nurses are being educated on proper use of insulin pens with return demonstration. Nurses are being educated on proper medication management of diabetes including potential adverse effect of complications including diabetes including potential adverse effects of complications including diabetic ketoacidosis, hypoglycemia and hyperglycemia. Nurses are being educated on difference between U-100 insulin and U-500 insulin concentration with the information provided in a red binder on each nurse's station. Revision made to Insulin Pen policy. Pharmacy to place a red sticker on insulin to indicate that it is high-alert medication with the potential to cause patient harm if used in error. Education of nurses initiated 08/30/22 and completion of removal plan target date 09/02/22. 6. V10 has been terminated. Last day of work 08/30/22. 7. The facility will monitor with QA (Quality Assurance) tool developed and DON (Director of Nurses) with target date 09/06/22.

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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** 30279 Based on interview and record review the facility failed to supervise and monitor three residents (R2) in the dining room and (R4 and R5) during resident smoke time. These failures resulted in R2 falling and sustaining a laceration to left eyebrow and suspicious complex ligamentous injury with potential cord compression and R5 sustaining injury/wounds to both knees, left eye swelling and redness, and a scratch under left eye. These failures have the potential to affect all 61 residents at risk for falls and all 34 smokers residing in the facility. Findings include: R2's medical record documented date admission as 06/29/22, with diagnosis information that includes but not limited to unspecified Dementia without behavioral disturbances, Displaced fracture of Proximal phalanx of the left index finger, subsequent encounter for fracture and routine healing , Pain Left hand, presence of unspecified Artificial Knee Joint, Vascular Dementia without behavioral disturbance, Primary Generalized (Osteo) Arthritis, Heart Failure and Unilateral primary osteoarthritis, right knee. R2's medical record showed that R2 had a fall on 07/14/22 and was sent to a local community hospital for further evaluation and treatment. R2 was then transferred to another community hospital for further evaluation and treatment. R2's medical record dated 07/13/22 timed 2:02pm (14:02) documented that R2 is confused needs redirecting, staff gave a full body shower resident complied, skin assessed, skin intact staff will continue to monitor. R2's MDS (Minimum Data Set) dated 07/06/22 coded R2 BIMS 00 indicating that R2 is severely cognitively impaired. R2's progress note dated 7/14/2022 17:26 (5:26pm) Health Status/Progress Note Note Text: Writer (V16 - RN) observed resident in dining room and heard a noise. Writer (V16) seen resident on her left side laying on the floor. Writer (V16) assessed resident and noted open area to the left side with minor bleeding. V/S taken B/P 114/69, RR 18, pulse 73, T 98.0, SPO 98 RA. Writer (V16) and CNA (V17) help resident back in chair. Resident voiced no pain. Writer (V16) asked how you fell resident stated, I was trying to get my shoes. Daughter in the building she made aware. MD called awaiting on call back. R2's potential fall plan of care initiated 06/29/22 documented that R2 is at risk for injury from falls with goals to reduce the likelihood of the resident experiencing a fall with target date 10/12/2022. R2's plan of care for ADL's documented that R2 has an ADL self-care performance deficit initiated 07/12/22, interventions documentation listed showed that R2 needs total assistance with staff participation with toilet use, transfer, bed mobility bathing, personal hygiene / oral care dressing and eating (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 08/24/22 at 1:48pm, V15 NP (Nurse Practitioner) was asked if she (V15) was made aware that R2 had any injury with the fall that occurred on 7/14/2022. V15 stated, I was not notified of any injury between 8am to 6pm. I'm not on duty after 6pm. The facility nurses will have to call either the PCP (Primary Care Physician) or the NP on call. I (V15) was not notified of R2 having any injury. V15 further stated, The facility staff are supposed to monitor and supervise the residents to prevent falls. On 08/24/2022 at 3:39pm V17 CNA (Certified Nurse's Aide) identified herself as helping to get R2 up off the floor after R2 had a fall on 7/14/2022. V17 stated, she (V17) remembers R2 and worked on the floor the day R2 fell . V17 stated, R2 was found on the floor in the dining area, and she (V17) was not the CNA assigned to R2. V17 stated, She (V17) did not witness R2's fall, but the nurse told her that R2 fell . V17 stated, She makes rounds every two to two and half hours because when they assume duty at 3pm to 11pm shift, almost all of the residents are usually up out of the bed. V17 stated, She (V17) helped in getting R2 off the floor and they (V16 and V17) physically lifted R2 of the floor. On 08/24/22 at 3:47pm, V18 (CNA) stated, I worked on the floor the day of the incident (7/14/2022), but I (V18) did not work with R2, and I (V18) do not remember what happened to R2 on 07/14/22. When asked how often V18 makes rounds, V18 replied, every one to one and a half hours (1 - 1 1/2). On 08/24/22 at 3:52pm, V19 (CNA) was identified as working with R2 on 07/14/22 when R2 fell . V19 stated, She (V19) was on duty but did not witness the fall and did not know where she was at the time of the fall. V19 further stated, I (V19) do not remember the last time I saw R2 before the fall on 07/14/22. On 08/24/22 at 4:02pm, surveyor asked V2 regarding the fall with injury R2 had on 7/14/2022. V2 stated, The facility did not get any report from the hospital about any injury. Originally R2 was sent to a local hospital and was later transferred to another local hospital. V2 stated, R2's family member wanted R2 to be sent to another hospital and then to another LTC. R2's emergency hospital record dated 7/14/2022 at 23:33 (11:33 pm) showed R2 was admitted on [DATE]. The report documented that R2 fell at the facility, had a 3cm (Three centimeter) superficial laceration on the left eyebrow used Dermabond on the area and there was no more bleeding at the site. Under reexamination/reevaluation imaging reviewed CT head showing no acute intracranial processes. CT neck showing concerns for cord compression currently. Given imaging result recommend need for emergent MRI to rule out cord compression at this time. Patient (referring to R2) will require escalation of care, spoke with (another hospital trauma center) who accepted patient (R2). Superficial laceration Dermabond shut with approximation of laceration. Diagnostic test result CT (Computer Tomography) Spine Cervical w/o contrast dated 07/14/22 at 20:48 (8:48pm) documented under impression that C1/C2/basion findings as described suspicious for complex ligamentous injury and potential cord compression. Question age-indeterminate atlantoaxial/rotatory subluxation and even low-grade occipital-axial dissociation. Recommend MRI and comparison to priors. The reason for the exam was for neck trauma. The report addendum documentation pointed out that this report containing critical findings was discussed with (Doctor on 07/14/22 at 10:37pm). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R4's medical record showed that R4 was admitted to the facility initially 11/18/2021. Last admitted was 08/22/22. R4's listed diagnosis includes but not limited to other specified Abnormal Immunological findings in serum, Alcohol Abuse Uncomplicated, Nicotine dependence, cigarettes uncomplicated, Other Psychoactive Substance Abuse in remission, and Major Depressive Disorder Recurrent, mild, Opioid Dependence uncomplicated, and Opioid use unspecified, uncomplicated. R4's Minimum Data Set (MDS) dated [DATE], Section C-brief interview for mental status summary score is (06) indicating R4 is cognitively impaired. R5's medical record documented that R5 was last admitted [DATE]. Diagnosis list includes but not limited to Epileptic Seizures related to external causes not intractable without status Epilepticus, Unilateral primary Osteoarthritis Left Knee, Alcohol Abuse, Effusion Left Knee, Acute Embolism and Thrombosis of Right Femoral Vein, Other Chondrocalcinosis Right Knee. R5's Minimum Data Set (MDS) dated [DATE], Section C-brief interview for mental status summary score is (11) indicating R5 is severely cognitively impaired. Review of R5's medical record progress notes showed the following documentation: V16 documented on 8/15/2022 between 2130 and 2140 (9:30pm and 9:45pm) R4 started to get physically aggressive and came up to another resident and started to punch repeatedly and pull R5 off the wheelchair. V26 LPN (Licensed Practical Nurse) documented at 2210 (10:10pm) in part R5 had a physical altercation with peer (R4) on the courtyard. Resident (R5) was assessed by writer, Writer (V26) noted swelling to the left eye and a small scratch under left eye. Left eye is red. No other bruise noted. V4 (Wound Care Nurse) documented that on 08/17/22 at 1:07pm that R5 had a skin tear to left and right knee with wound care department will be monitoring. R1 medical record documents admitted [DATE]. R1's diagnosis includes but not limited to Obesity, unspecified, Type 2 Diabetes Mellitus with Hyperglycemia, Essential Hypertension R1's Minimum Data Set (MDS) dated [DATE], Section C-brief interview for mental status summary score is (14) indicating R1 is cognitively intact. On 8/24/2022 at approximately 4:29pm Surveyor asked R1 what staff were on patio. R1 stated, There was no staff out there to help. We all could have been attacked, and I'm not staying here. I (R1) want to leave. V12's Progress Note dated 8/22/2022 documents R1 is A+O (Alert and Oriented) x 3. On 8/25/2022 at approximately 12:16pm surveyor asked R5 if staff were present on the patio. R5 stated, No, staff were there. On 8/25/2022 at 12:29pm surveyor asked R4 if staff were present on the patio. R4 stated, No body (referring to staff) were there. (continued on next page)

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	09/21/2022

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 0689 Level of Harm - Actual harm Residents Affected - Few	On 8/25/2022 at 2:03pm V1 (Administrator) stated, The security guard on duty did not see them (R4 and R5) have any contact with each other (R4 and R5). He (V24) was the one supervising the smoking patio at the time (referring to incident). On 8/30/2022 at 9:41am V12 (LPN) stated, I (V12) was called downstairs that there was an altercation between two residents (R4 and R5). R4 was not downstairs, he (R4) was back on the unit in his (R4's) room. R4 did not give me (V12) any details about the altercation. Surveyor asked V12 was staff supervising or monitoring the residents on the patio. V12 stated, That is a good question, I (V12) will have to find out about that. V12 was unable to state who was supervising residents on patio at the time of the incident. On 08/30/22 at 12:23pm R6 stated There was no staff present at the time, but the other resident went and called the security guard (V24). R6's medical record showed that R6 was admitted to the facility originally on 06/08/2020 and initial admission of 03/15/2021. Diagnosis includes but not limited to Type 2Diabetes Mellitus with Hyperglycemia, Type2 Diabetes Mellitus with Diabetic Neuropathy unspecified, other seizures, Shortness of breath, Acute bronchitis, Wheezing, Chest pain, other visual disturbances, Acute Embolism and Thrombosis of unspecified Deep Veins of Right Lower Extremity. R6's Minimum Data Set (MDS) dated [DATE], Section C-brief interview for mental status summary score is (15) indicating R6 is cognitively intact. On 08/30/22 at 12:24pm, interview conducted with R7 regarding the physical altercation between R4 and R5. R7 stated, The residents were on the smoking patio smoking when R4 attacked R5. R4 was hitting R5 and throwing R5 out of the wheelchair to the floor. R7 stated, R4 was kicking R5 on the head and the body and because the staff was not around the other resident had to hold R4 away from R5. R7 stated, There was no security guard at the time so one of the residents had to run and called the security staff. R7 asked surveyor how did you (surveyor) know I (R7) was there during the incident. Surveyor told R7 that V1 told surveyor. R7 then stated, V1 told R7 that V1 saw him in the video. R7's medical record showed that R7 was admitted to the facility on [DATE]. Diagnosis includes but not limited to Essential Hypertension, Post Traumatic Stress Disorder, unspecified, Major Depressive Disorder, Fracture of Orbital Floor, Left Side. R7's Minimum Data Set (MDS) dated [DATE], Section C-brief interview for mental status summary score is (12) indicating R7 is mildly impaired. On 8/30/2022 at approximately 1:30pm survey asked V1 to see the video from the incident on 8/15/2022. V1 stated, There was no video. According to facility investigation, documented during investigation by V1 (Administrator) on 8/15/2022, V24 stated, V24 heard yelling in the patio and when he approached, he observed (R4 and R5) getting into an altercation and R4 was standing beside R5. V24 did not see R4 had any physical contact with peer (R5) but peer (R5) was the one that told him (V24) that R4 assaulted him (R5). (continued on next page)

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	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ryze West	5130 West Jackson Boulevard Chicago, IL 60644

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During this survey V2 made attempts to call V16 (RN) and V26 (LPN) with no response. V2 stated V16 was on vacation. Surveyor attempted to call V26 on 8/31/2022 and 9/1/2022 with no response and attempted to call V24 on 8/31/2022 with no response. On 9/1/2022 when surveyor call V24, V24 identified himself as V24 and when surveyor identified self as surveyor, V24 hung up the phone. Surveyor called V24 back and there was no answer. The facility Falls Management policy presented with revised date 6/21 documented in part that the facility is committed to maximizing each resident's physical, mental and psychosocial wellbeing while preventing all falls is not possible, the facility will plan for preventive strategies and facilitate as safe an environment as possible. Facility guideline following a fall incident includes but not limited to completing a fall event. This event includes the circumstances surrounding the fall devices in use, full body observation of injury, pain, range of motion and neuro checks as needed. All incident and accident with serious physical injury will be initially reported as required to the Health Department. A final written investigation is required by the Department of Public Health within seven days of incident. The facility policy on Smoking presented with review date of 6/21 documented in part that smoking is a right for our residents. Residents are allowed to smoke only in designated places. Responsibly Party: All facility staff. Guideline: includes but not limited to: 8. The designated smoking areas will be supervised during the designated smoking times. 10. Residents will be supervised during smoking unless the IDT determines the resident can safely smoke unsupervised during non-designated smoking times. Facility documented Smoking times: listed includes but not limited 9pm to 10pm.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 30279 Based on observation, interview and record review the facility failed to follow current hand hygiene standards of practice to prevent nosocomial infection and failed to follow the manufacturer's guideline and facility policy on insulin pen administration to prevent medication contamination for one resident (R6) reviewed for infection control and prevention practices. This failure affected R6 whose insulin was transferred from an insulin pen to an insulin syringe. This has the potential to affect all 38 residents receiving insulin. Findings include: On 08/30/22 at 12:30pm, surveyor observed V10 LPN (Licensed Practical Nurse) remove 100U insulin syringe from medication cart, open the insulin syringe, and use the insulin syringe to draw insulin from the insulin pen that was marked 500 units/ml without doing any hand hygiene before or after drawing up the insulin. V10 was observed administering insulin to R6 without performing hand hygiene before donning gloves. After V10 administered insulin, V10 removed the gloves and did not perform hand hygiene. V10 then proceeded to touch R6's belongings, bed side table then R6's wheelchair handle. When this observation was brought to V10's attention, V10 stated, I can wash my hands later right (while looking at the surveyor). Surveyor asked V10 what the risk was of contaminating the insulin during the transfer of insulin from the pen to the syringe. V10 did not provide an answer to surveyor. On 09/03/22 at 10:12am, interview with V27 (Pharmacist) stated in part, it is not recommended to draw from the insulin pen into a syringe because it can jeopardize the sterility of the pen and the insulin. The facility policy on Insulin Pen Usage dated 06/2021 documented that the policy is to provide the staff with guidance on accuracy of insulin administration and dosing. Listed responsible party are RN (Registered Nurse) or LPN (Licensed Practical Nurse). Policy statements includes but not limited to never use syringe to draw insulin out of an insulin pen cartridge. The facility Medication administration policy presented with review date 11/2021 documented that all medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis. Listed responsible party are RN (Registered Nurse) or LPN (Licensed Practical Nurse). Listed guideline includes but not limited to Following special instruction written on the label. The facility policy on Hand hygiene dated 06/17/2020 documented that infection prevention practices centered on hand hygiene protocols can save lives across all healthcare facilities. Facility supports practicing hand hygiene which includes the use of alcohol-based hand rub or hand washing to prevent the spread of pathogens and infections in healthcare settings. Under glove use the policy pointed out that gloves are not a substitute for hand hygiene and hand hygiene should be performed immediately after removing gloves. The facility policy titled Gloves with revision date 10/21 in part hand hygiene is performed after removing gloves.