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	12/13/2022

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	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** 15301 Based on interview and record review, the facility failed to ensure the safety of residents by not monitoring and preventing a resident (R4) from receiving and using an illegal drug. This failure resulted in R4 overdosing on heroin, requiring transfer and treatment at local hospital for treatment. Findings include: R4's current medical record (Face Sheet, Progress Notes, MDS-Minimum Data Set) documents: R4 is a cognitively intact [AGE] year-old admitted to the facility on [DATE] with diagnoses including but not limited to: Opioid Abuse, Opioid Dependence, Cocaine Use, Acute Respiratory Failure with Hypoxia and Congestive Heart Failure. Progress note dated 11/8/2022 at 3:20 AM documents in part: Nurse on duty notified by CNA to come to check to room to check on R4. Writer immediately rushed in resident('s) room and observed resident unresponsive, no movement of the entire body. Eyes rolled to back of head, extremely diaphoretic, unresponsive to sternal rub, and with agonal respirations. Code blue/rapid response initiated immediately, and staff responded. 911 called. Resident was taken to (local hospital). Facility's investigation (undated) documents in part: 11/8/22, (R4) noted to be unresponsive at 03:20 (AM). Code Blue called, Narcan administered and effective. Evidence of substance abuse note by nurse-small blue empty bag with whitish brown powder and rolled up bill/powdery residue. Transferred to ER for evaluation. Resident returned to the facility with no new orders. Hospital paperwork indicates that drug screen was positive for opioids. Progress note dated 11/08/2022 at 3:15 AM documents in part: Writer was told by staff that resident(R4) was in room, unresponsive and then a code blue/rapid response was overheard in speakers. Upon entering room, resident(R4) observed with eyes rolled to back of head, extremely diaphoretic, unresponsive to sternal rub, and with agonal respirations. 911 already called. Open carrier bag sitting on top of resident while code ongoing and all staff responding. Writer found a blue small empty drug bag with only a residual whitish brown powder and rolled up bill also with powdery residual. He(R4) was given multiple rounds of Narcan. Slowly, resident(R4) began to come out of stupor and respirations increased. He(R4) soiled himself and began to vomit. 911 EMTs and police arrived and were given report on his(R4's) status and presentation. (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 0689 Level of Harm - Actual harm Residents Affected - Few	Progress Note dated 11/08/2022 at 7:02 AM documents in part: Received a telephone call from (local hospital) regarding resident(R4), spoke with RN, who stated resident will be returning back to facility. DX (diagnosis) Opioid overdose. emergency room Record Note 11/08/2022 documents: opiate OD s/p Narcan in (is) bedridden resident(R4) of nursing facility. Unexplained access to heroin. 12/08/2022 at 12:21 PM, V6 (LPN-Licensed Practical Nurse) said, when I called R4's name there was no response, no rising/fall of chest. I shook R4, checked pulse. There was no response to sternal rub. I called 911, called code blue. Nurse Supervisor (V10) responded, requested Narcan because V10 knows R4 has history of drug overdose. I remembered small black pouch or purse next to resident on bed, V10 saw the bag. There was a little, small plastic clear bag on top R4 with a whitish residue. I did see a male resident go into R4's room an hour or so before R4 was (found unresponsive). I don't know the resident's name; he is no longer at the facility. V6 stated their bags are not checked by security when they come to work. 12/07/2022 at 9:13 PM, V10 (Registered Nurse/Evening Nurse Supervisor) said, I was the manager on duty, they called rapid response/code blue. When I got there, R4 was extremely diaphoretic, sweating bullets, agonal respirations of 2-3 per minute, eyes rolled to back of head, and was non-responsive to sternal rub. I saw a black bag in bed by the resident, it was open. I saw a blue baggy with white residue and a rolled-up bill. I called for nasal Narcan; I gave it but R4 didn't respond. I couldn't appreciate pulse, or it was faint. I gave second round up Narcan. At that point we thought we were going to have to start compressions. Then 30-40 seconds later, R4 took a deep breath, like R4 was coming out of the water. R4 started breathing normally. R4's respirations gradually returned to normal. Then R4 just woke up. 12/09/2022 at 10:20 AM, R4 said R11 sold R4 heroin. R11 came into my room. I gave R11 $20 dollars for two bags of heroin. The next thing I remember is the paramedics in my room. Everyone knew R11 was the go-to guy (to get heroin). V1 (Administrator) met with me after I returned to the facility from the hospital. V1 asked me, who gave you the heroin? I told V1, I had it with me. V1 said, no you didn't. I saw (on the camera) R11 coming out of your room. I said to V1, then why are you asking if you already know? They knew R11 was selling it, R11 kept coming to my room. Drugs are still coming in (to facility), residents are still using (did not provide any additional information). 12/07/2022 at 3:52 AM, V1 said they didn't know how R4 got the heroin. V1 said they did not review tape and that V11 (Regional Nurse Consultant) completed an investigation. 12/09/2022 at 4:44 PM, V11 (Regional Nurse Consultant) said, I completed the investigation. I don't feel that I could come up with a concrete way that R4 got the heroin. For this situation, we suspect that something may have come over the patio (fence). I did not review tape. 12/08/22 at 4:13 PM, V12 (Licensed Practical Nurse/3rd Floor Nurse Supervisor) said, What I know is that R11 visited R4's room that night. I was told by my night nurse (V6). V6 was working the 3rd floor that night. I was told R1 visited R4's room at approximately 1 or 2 in the morning and approximately 30 minutes to an hour after R11 went into R4's room, R4 was found unresponsive. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R4's care plan for substance abuse (created and initiated on 11/09/2022) documents under focus: resident has a history of substance abuse while in the community; under goal: resident will address chemical dependency by attending program as well as external chemical dependency treatment through next review. There are no interventions documented. Facility did not provide documentation that R4 attended programs.