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	04/06/2023

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** 45111 Based on interview and record review, the facility failed to supervise R6 who is assessed as high risk for falls and resides on a memory care unit. This failure resulted in R6 being left unattended, falling, and sustaining 3 sutures to the back right side of the head. This failure affected R6 in a sample of 11 residents reviewed for falls. Findings include, Facility's incident report (2/17/23) to state agency documents in part: R6 with diagnosis of Hypertension, Major Depressive Disorder, Dementia, Epilepsy, Cirrhosis of Liver, Cardiomegaly, Multiple Sclerosis, Osteoarthritis. Location of incident: Resident's Bathroom. Description of incident: R6 is a [AGE] year-old that admitted to facility in September 2015. She requires extensive assist from staff for bed mobility, transfers, dressing, toileting activities, and personal hygiene. Her fall risk assessment indicates she is a high risk for falls due to medication regimen, incontinence, and gait imbalance. R6 has not had any falls in nearly a year. The interdisciplinary team routinely reviews her fall prevention care plan based on her personal fall risks. The care plan includes keeping her call light in reach, maintaining her bed in the lowest position, staff providing redirection as needed to prevent impulse changes and time of day as needed. On February 16, 2023, R6 was assisted to the bathroom by V5 CNA. After assisting R6 to the restroom and toilet, V5 instructed R6 not to get up until she returned to assist her to which R6 replied, Okay. V5 informed R6 that she would be right back. V5 then left the room to go get something from the Clean Utility Closet and immediately returned to assist R6. Upon her return to the bathroom to assist R6, V5 observed R6 on the floor. She immediately informed R6's Nurse, V9. V9 immediately assessed R6 and noted a small amount of blood to the back of her head on the right side. MD notified of the fall and assessment findings. New orders received to transfer R6 to the Emergency Department for further evaluation. R6's state guardian was notified of the incident and hospital transfer. R6 was transferred to Hospital via Ambulance. CT of head resulted negative; 3 sutures were placed to a small laceration on the back right side of her head. On 3/28/2023 at 11:46am, R6 said she hit her head when she fell and does not remember what hit R6 on the head. R6 said, she got stitches on her head and is now healed. R6 pointed to the middle of her head and said I am ok, they take good care of me. R6 said she sometimes tries to get up without staff assistance and staff keep reminding her not to get up without help. R6 said, she knows how to use the call light. (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	On 3/28/2023 at 11:56am, V6 (Licensed Practical Nurse) said R6 has MS (Multiple sclerosis) and is impulsive and thinks she can do a lot for herself and be independent and she cannot. V6 said, R6 knows how to use the call light but sometimes R6 thinks she can do things for herself without staff assistance and will not use the call light, therefore, staff keep an eye on R6 to keep her safe. On 3/28/2023 at 12:59pm, V5 (Certified Nurse ' s Assistant-CNA) said she took R6 to the bathroom on 2/16/2023 and told R6 to not move without V5 helping R6. V5 said, R6 is able to use the call light, and V5 stepped out of the bathroom to go to the clean utility, which was right opposite R6's bathroom, and as V5 was going out of the room, V5 heard a noise, V5 went back to the washroom room and found R6 on the floor by the toilet sitting on the floor. V5 said, she went to get the nurse, and the nurse came in and assessed R6 and laid R6 on the bed. V5 said, V5 then left out of the room and left the nurse to complete assessments. V5 said, R6 is getting weaker due to diagnosis of MS and that is why R6 needs to be assisted and monitored while she is in the bathroom, but R6 is able to use the call light. V5 said, R6 is impulsive and will do what she wants to do, therefore staff must keep reinforcing to R6 that R6 cannot perform ADLs (Activities of Daily Living) by herself. On 3/29/2023 at 11:36am, V15 (Restorative Director/Falls Coordinator-LPN) said, when a resident is extensive assist for toileting, it means it's more of a hands on because the resident may not be able to do the task on their own. V15 further said, that extensive assists like R6 have to be physically assisted with toileting and transferring, and staff have to be near R6 when R6 is using the bathroom so that staff can assist if needed, to prevent falls. V15 said, R6 has some cognitive deficits but understands what she is being told, however, R6 is impulsive and does what she wants to do. V6 said you could turn your back and R6 will do what she wants, even when you tell her not to try to stand. V15 said, most of the times staff stay with R6 and R6's room is near the nursing station. V15 said, staff were in-serviced to bring all the necessary stuff needed for changing a resident when they take a resident to the bathroom. V15 said, staff were also in-serviced on giving residents privacy when they use the bathroom, but still keep an eye on residents like R6 who are on the memory care unit because of dementia. On 3/29/2023at 1:02pm, V2 (Director of Nursing-DON) said, as long as the resident has been assessed for call light use and the assessment shows they can use the call light, they can be left in the bathroom by themselves for privacy, even if they are in the memory loss unit. V2 said, R6 was assessed for call light use and assessment documented R6 is able to use call light to get staff attention. R6's last call light assessment was completed in 7/10/2022. R6 was not assessed for Call light use post falls. V2 said after the fall on 2/16/2023, R6 has had two more falls on 2/28/2023. On 4/05/2023 at 3:35pm, V24 (Nurse Practitioner) said, for a resident with a diagnosis of dementia, is impulsive, and has been assessed for extensive, one person assist for toilet use, that resident should not be left alone in the bathroom. V24 said, even if R6 had been assessed for call light use, R6 can forget to use the call light since R6 has a diagnosis of dementia and is impulsive. V24 said, potential harm for residents who are assessed as needing extensive one person assistance for bathroom use is falls with injury if left alone in the bathroom. V24 also said, the facility staff should follow their policy on resident supervision, however V24 was not aware what the policy was. R6's Brief Interview for Mental Status (BIMS) dated 2/08/2023, documents score of 12, R6 has slight cognitive impairment. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R6's MDS (Minimum Data Set) dated 2/20/2023 documents R6 needs extensive assistance with one person physical assist for Bed mobility, Dressing, Transfer, Locomotion on unit, Locomotion off unit and Toilet use. Review of R6's progress notes document R6 fell again on 2/28/2023 at 15:54 and again at 20:14. R6's care plan revised on 2/16/2023 documented R6 had an actual fall, and further documents R6's interventions, dated 2/17 to prevent falls include: Encourage R6 to sit in a supervised area as tolerated when out of bed. Staff documented to supervise R6 include: CNAs (certified Nurse Assistant) and RN/LPN (Registered Nurse/Licensed Practical Nurse), redirection as needed to prevent impulsive changes. R6's care plan continue to document that R6 has a HX (history) of being observed throwing herself on the ground and attempting to get up without staff assistance. Goals for this focus is documented as: CNAs (certified Nurse Assistant) and PLN (Licensed Practical Nurse), to assess and anticipate R6's needs: food thirst, toileting needs, comfort level, body positioning, pain, etc. Another care plan focus area for R6 is dated 5/24/2022 documents: R6 is alert to surrounding with some long- and short-term memory deficits, cognitive skills are somewhat impaired due to a diagnosis of Dementia. R6 enjoys listening to music, watching westerns, reminiscing this and that trivia. Facility policy (10/21) Safety and Supervision of Residents documents in part: 2. Staff shall use various sources to identify risk factors of residents, including the information obtained from the medical history, physical exam, observation of the residnet and the MDS. Facility policy titled Fall management, dated 8/14, 6/21, 6/22, 2/23 documents: This facility is committed to maximizing each resident's physical, mental and psychosocial wellbeing. While preventing all fall is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible. All resident falls shall be reviewed, and the resident's existing plan of care shall be evaluated and modified as needed. Facility Assessment tool dated 01/04/2023 documents in part: Provide person centered/directed care, Psycho/social/spiritual support: Identify hazards and risks for residents