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	05/08/2024

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 0600 Level of Harm - Minimal harm or potential for 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** 44314 Based on interview and record review, facility failed to protect a resident from physical abuse. This failure affected one resident (R12) of seven residents reviewed for abuse. This failure resulted in R11 and R12 having an altercation. R11 put R12 into a headlock and scratched R12's face. Findings Include: Facility's Investigation Report (dated 02/29/2024) states: R11 noted with agitation while walking with staff member and he began flailing his arms, in the process of flailing his arms resident scratched R12, while he was sitting in the dining area. R12 was immediately removed from common area and placed with social services with de-escalation techniques initiated. MD made aware with orders received to send resident out to [community] hospital for psychiatric evaluation, orders noted and evaluated. Nursing staff and social services were successfully able to deescalate the situation and remove R11 from the common area and place him on 1:1 supervision until he was transferred to [community] hospital for psychiatric evaluation. R12 was evaluated after removal of R11 and stated that he was startled by R11 but that he felt safe and comfortable and exhibited no distress. In conclusion, R11 suffers from altered mental status, legal blindness and schizophrenia. Resident could not see R12 seated in his wheelchair near him. Abuse Prevention Policy (dated 10/2022) states: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. R11's Face Sheet documents resident is a [AGE] year-old with diagnoses including but not limited to: legal blindness, as defined blindness, as defined in U.S.A, unspecified psychosis not due to a substance or known psychological condition, unspecified abnormalities of gait and mobility, lack of coordination, schizophrenia, glaucoma, essential hypertension, low back pain, altered mental status. R11's Care plan (dated 11/30/2023) documents that R11 exhibits the symptom of resisting care which is related to his dx. of legal blindness, as defined blindness, as defined in U.S.A, unspecified psychosis not due to a substance or known psychological condition. R11's care plan (dated 02/29/2024) documents that R11 memory is impaired, and resident has difficulty with decision-making, insight. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MDS section C (dated 12/31/2023) documents that R11 has a BIMS score of 10, indicating that R1's cognition is moderately impaired. R12's Face Sheet documents resident is a [AGE] year-old with diagnoses including but not limited to: hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, cognitive communication deficit, unspecified lack of coordination, abnormal posture, weakness, cerebral infarction. R12's Care plan (dated 02/27/2024) documents that R12 is at risk for falls. R12's comprehensive assessment reveals factors that may increase his/her susceptibility to abuse/neglect including history of substance abuse. MDS section C (dated 03/04/2024) documents that R12 has a BIMS score of 14, indicating that R12's cognition is intact. On 05/02/2024 at 12:50pm V1 (administrator) stated, There was an incident between R11 and R12 on 02/29/2024. R11 walking in the dining area with V17 (activity aide). They were talking, and I guess she said something to R11 that triggered R11, and he just started swinging. R11 is blind. When he started swinging, V17 ran, and R12 was the next thing closest to R11. R11 did not know that R12 was sitting there. R12 is in a wheelchair. R12 sustained scratches to the face. We were able to get social services and security to separate the R12 from R11. Once R11 calmed down, we separated him from other residents. R5 also attempted to help. R12's injuries were superficial, and the wound nurse saw the resident until the scratches healed. I think that R12 was shaken up at first after being scratched. After R12 calmed down, R12 expressed that he was ok and that he understood that he was not attacked on purpose, that he was scratched on accident. I reported this incident to the state agency. Per my investigation, abuse was not substantiated, the incident was an accident, and it was not intention. R11 was discharged . After this incident, the facility tried to do an involuntary discharge, but the hospital did not honor the paperwork. R11 had other incidents where he was aggressive towards staff, so we discharged the resident. On 05/02/2024 at 4:47pm V1 (administrator) stated, I am the abuse prevention coordinator. The facility's policy is the residents have the right to be free of abuse. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/02/2024 at 2:00pm V17 (activity aide) stated, On 02/29/2024, I am the one that got R11 out of his room because he was aggressive, and he was throwing things in his bedroom. I decided to bring R11 out of the room just so R11 can listen to music. I was having doing resident activities at the time, and I wanted to have R11 join the activities so that he can listen to music, and I could re-direct R11 so that he can calm down. Every day, I would bring R11 down to activities and I would take R11 to smoke. On that day R11 was already aggressive. R11 was talking about his money, he was agitated regarding his money. R11 was talking about his trust fund and that is what he was agitated about. R11 was sitting in the dining room, when he got up and he was touching the wall, going around in a circle. He almost tripped over a cord, and I got up to prevent him from falling, so I grabbed him to prevent a fall. R11 didn't fall, he just started swinging on me when I held his arm. R11 just started swinging on me, hitting me on the left side of the ear, the top of my lip and my face. As I was trying to move out of the way so that R11 will stop hitting me, R12 was sitting in a circle in his wheelchair and I guess the way he was positioned, R11 grabbed a hold of R12's neck and put him in a choke hold. R11 was holding R12 with his hands around R12's neck. I was screaming for help. Somehow R12 sustained scratches to his face when R11 was holding R12 in a choke hold. The only way I was able to stop the situation was because another resident intervened and helped. Residents had to intervene. R5 assisted me in helping me with getting R11 off of R12. R12 had dropped his money and his cigarettes, and we found the money and gave it to him. We found R12's money, but we could not find the cigarettes. Somehow, R11 found the cigarettes on the floor and picked them up and placed them in his pocket. R11 is legally blind. How the cigarettes were found was by V18 (wound care). V18 was the one that was able to relax R11. V18 was the one that was able to find the cigarettes. The police were called, and I did the police report. The two residents were separated immediately once I was able to get assistance. R11 was sent out to the hospital. R12 had scratches. The incident occurred because R11 got agitated and he is blind and he was having a behavioral episode and R12 just so happened to be close to R11, and that's how R11 was able to grab R12. On 05/02/2024 at 2:58pm V19 (wound care) stated, I remember V12. On 02/29/2024, it is documented that R12 sustained scratches to the face from an altercation. The scratches were not deep and did not require any wound care. The scratches required to be monitored. First aid was rendered, and no treatment was required from the treatment nurse for the scratches. We took pictures of the scratches. The scratches healed. On 05/07/2024 V20 (wound care) stated, On 02/29/2024, I am not sure what took place, and what led to it, but I heard the code. When I got to the floor, R11 was upset, and he was sitting on the floor. I can tell he was upset. I wanted to calm him down and I told him that we can go downstairs and have a cigarette and talk about what happened. R11 just told me that he was ready to leave. R11 didn't tell me what happened. The police came and questioned R11. R11 told me that he picked up a wallet and cigarettes thinking that it was his, but it belonged to R12. R11 is blind and he thought that the cigarettes and wallet he found on the floor belonged to him. R11's Progress Note (02/29/2024) documents, Resident became agitated while walking with staff member, he began flailing his arms and, in the process, he scratched a male co-peer seated in dining area, placed on 1:1 with social services, MD made aware with new orders to send resident out to [community] hospital for psych evaluation, orders noted and implemented. R11's Progress Note (02/29/2024) documents, Writer placed call to [community] hospital and spoke with nurse J. He stated to writer resident was admitted for psych evaluation. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R12's Progress Note (dated 02/29/2024) documents, While seated in dining area watching television, resident was scratched by male co-peer, co-peer immediately removed from common area, first aid provided to resident, resident family and MD made aware, social services made aware for any needed support for resident, nursing staff continues to monitor.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35432 Based on interview and record review, the facility failed to report an injury of unknown origin to the regional office. This failure affects one of three residents (R9) reviewed for injury of unknown origin in a total sample of 19. Findings include: R9 is a [AGE] year-old male. R9 ' s diagnoses are but not limited to stroke affecting the right side of the body, stroke, aphasia, major depressive disorder, adult failure to thrive, and anxiety. R9 ' s MDS dated [DATE], notes R9 is not alert. Progress note dated 12/10/2023, notes R9 noted with some swelling, redness, pitting edema and warm to touch to right contracted arm. Patient vitals within normal levels. No signs or symptoms of shortness of breath, pain, anxiety, or distress noted. No adverse reactions to antibiotics. For ten days. Patient remains stable and resting currently. Progress note dated 12/10/2023, notes writer endorsed x-ray of right elbow to nurse practitioner with new orders to send patient out to local hospital due to x-ray stating (flexion deformity with fracture of the distal humerus). As needed Tylenol administered per doctor ' s orders. On 05/02/2024, at 1:42 PM, V1 (Administrator) stated, I did the investigation. V22 (Licensed Practical Nurse) notified me of R9 ' s arm. The staff though it was cellulitis at first. The staff and the nurse practitioners were monitoring him, and he was being treated with an antibiotic. This went on for about five days. I believe on the 9th; the nurse practitioner ordered the x-ray. The x-ray showed he had a fracture. I was the administrator at the time. I started my investigation and did not report it. It was not a suspicious because staff had been monitoring the arm. I figured it was something systemic. When I started my investigation, I got statements from the staff that was working for a seven-day period. I got the x-ray results. I got the results from the hospital. I looked at his paperwork when he was first admitted to us, there was nothing mentioned. He had three fractures and two were old. One was comminuted fracture. This means the bone was split in area. The hospital never did anything in depth on this resident due to his drug history. There was no bone scan or testing done to diagnoses osteoporosis or to see if he had some disease. I did ask the staff about abuse as well. If they witnessed or suspected anyone and they said no. The nurse practitioner agreed that it was related to the pathology. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/02/2024, at 2:23 PM, V22 stated, The aide is the person that told me about R9 ' s arm. I went in and assessed it. His vitals were normal and there was no temperature. I noticed it was swollen, red, and warm to touch. When I touched it, R9 did grimacing with his face. I did administer Tylenol through his g-tube (stomach tube). I immediately contacted the nurse practitioner and let her know what was going on. At the time, she ordered him some antibiotics. The way I was describing it to her, she believed it was cellulitis. She ordered him some antibiotics. It was the next day; I was not comfortable with his arm. I asked her if I could order an x-ray. I ordered the x-ray. Once the results came back, I relayed the results to the nurse practitioner. The results noted R9 ' s elbow may have been fractured. She stated to send him to the local hospital. He was sent out. When I did see him again, he had a soft splint on his right arm. I contacted his family as well. He used to thrash around in bed a lot. He used to try to move around in the bed. The floor mats were always down on the floor. He would favor the left side of the bed. Staff pushed his bed closer to the wall and put the mats in place. I do not recall if he was a high risk for falls. I do not know if his injury is suspicious because the hospital, he had old fractures. I do believe it should be thoroughly investigated and reported to the state. On 05/02/2024, at 2:37 PM, V23 (Nurse Practitioner) stated, Another nurse practitioner was seeing R9. But for insurance reasons I had to see the resident. On the December 8th, 2023, the other nurse practitioner called me and told me that R9 ' s arm is presenting as cellulitis. He was initiated on Bactrim DS every twelve hours for ten to twelve days. The following day the nurse called me and said that his arm looks worse. He had gotten two rounds of antibiotics. I put in an order for and x-ray and doppler of the upper extremity with labs. I also added Augmentin (antibiotic) for better coverage while everything was pending. The x-ray came back and showed a fracture. R9 was sent out to the hospital. He had a fracture of the distal humerus. The fracture was just above the elbow. This was not suspicious to me. He had a rapid weight loss and other health issues. Staff and I thought it was cancer. I was not surprised that he had a fracture because his overall health is not good. Due to his health history and his health being so poor, it very easily could have been a pathological fracture. Facility policy titled Abuse Policy and Prevention Program, dated 10-2022, notes an injury should be classified as an injury of unknown source when both of the following conditions are met: the source of the injury was not observed by any person, or the source of the injury could not be explained by the resident and he injury is suspicious because the extent of the injury or the location of injury (e.g. the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. If classified as an injury of unknown source the person gathering the facts will document the injury, the location and time it was observed, any treatment given and notification of the resident ' s physician responsible party. The Department of Public Health will be notified.