

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145661	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/05/2025
NAME OF PROVIDER OR SUPPLIER  Ryze West		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46342</p> <p>Based on observations interview and record review the facility failed to keep three residents (R8, R10, R11) safe from a fire incident that occurred on 1/6/25. The facility failed to a.) properly assess and b.) maintain monitoring of R8's motorized wheelchair per the facility preventative maintenance policy in accordance with the manufactures guidelines. This failure resulted in three residents (R8, R10, R11) being involved in a fire and exposed to smoke. This failure has the potential to affect all 221 who reside in the facility.</p> <p>This was identified as an immediate jeopardy situation which began on 01/06/25. On 01/24/25 the administrator was notified of the immediate jeopardy. The abatement plan was sent via e-mail on 1/28/25 and not accepted. The abatement plan was resubmitted on 1/29/25 and 1/30/25 and accepted on 1/31/25. The immediate jeopardy was removed on 02/04/25. However, the deficiency remains at the second level of harm until the facility determined the effectiveness of the implementation of the removal plan.</p> <p>Findings include:</p> <p>R8's admission record showed admitted on 12/7/20 with diagnoses not limited to Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, Dysphagia oral phase, Anemia, Peripheral vascular disease, Absence epileptic syndrome, Other hereditary and idiopathic neuropathies, Encounter for attention to gastrostomy, Hyperlipidemia, Unspecified dementia, Chronic embolism and thrombosis, Gastro-esophageal reflux disease, Crohn's disease, Obstructive and reflux uropathy, Other sequelae of cerebral infarction, Type 2 diabetes mellitus with diabetic neuropathy, Aphasia, Essential (primary) hypertension, Heart failure, Major depressive disorder.</p> <p>MDS (Minimum Data Set) dated 11/14/25 reflects: R8's cognition was severely impaired. R8 needs partial/moderate assistance with oral hygiene, dependent with toileting hygiene, Substantial / maximal assistance with shower / bathe self, upper and lower body dressing, personal hygiene, chair / bed, and toilet transfer.</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 145661
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/21/25 At 12:05pm R8 was sitting up on a motorized wheelchair, alert, and responsive. R8 is non-verbal but able to make needs known by hand and head gestures. During interview R8 was able to recall the fire incident on 1/6/25, R8 nodded her head up and down, indicating yes when asked if she was involved and if she almost got burned. R8 then pointed to where the fire was and pointed and motioned to her left towards the arm and pointed at the back of the wheelchair. R8 then pointed the left side of her shoulder. R8 appeared scared and anxious. Surveyor then asked R8 were you scared? and R8 nodded her head up and down, indicating yes. Surveyor further asked are you still scared and R8 nodded her head again up and down, indicating yes and also appeared to become teary-eyed. Surveyor asked R8 if this was the wheelchair and R8 gestured to the chair and nodded her head up and down, indicating yes that she is still using the same motorized wheelchair. R8 also pointed to her bed. Surveyor observed that R8 was in the same room where the fire incident happened and noted dark brownish and black spots and markings on the side of the railing on R8's bed closest to the door. Surveyor also observed the footboard of R8's bed. The footboard appeared to have small charred circle like markings to the black strip at the top of the footboard, as well as melted portions to the black stripping at the top of the footboard.</p> <p>On 1/21/25 at 3:25 PM, R10 stated she was lying in her bed next to R8's bed and smelled smoke so R10 yelled fire. R10 stated she was concerned about R8 because the fire was on R8's bed and she was worried R8 could get burned. R10 stated she called out to get help, but no one came so R10 stood up and got into her wheelchair to go for help. R10 stated the staff pulled me from the room into the hallway.</p> <p>On 1/22/24 Surveyor Conducted Observations to all 3 floors to review fire extinguishers. It was observed that all fire extinguishers had been recently inspected and one of the fire extinguishers where the fire occurred had been filled on 1/8/25.</p> <p>When conducting observations on 01/22/25 R10 spoke to the surveyor again and stated to the curtain (that separates their beds/personal space) was opened and that was how she could see fire on R8's bed. R10 stated I saw the flames and it was big, big and a lot and it was scary. When asked if R10 had been smoking or had her lighter in the room R10 stated, no.</p> <p>R10 is a [AGE] year-old female admitted to the facility 06/08/2023 with diagnosis included but not limited to Chronic Kidney Disease, Emphysema, Hypertension, Major Depressive Disorder, Opioid Abuse With Withdrawal, Insomnia, Solitary Pulmonary Nodule, Alcohol Abuse, Fall From Bed, Generalized Muscle Weakness, Alcohol Use, Nicotine Dependence Cigarettes, Repeated Falls, Reduced Mobility, Abnormalities Of Gait and Mobility, Need For Assistance At Home and No Other Household Member Able To Render Care, Vascular Dementia. R10's MDS dated [DATE] documents in part, R10 requires supervision/touching assistance with chair/bed to chair transfers and with walking 10 feet, walking 50 feet with two turns, and walking 150 feet. R10 uses a manual wheelchair and smokes. R10's BIMS (Brief Interview for Mental Status) indicates R10 is moderately cognitively impaired.</p> <p>On 1/21/25 at 3:30 PM, R11 stated R11 is blind and cannot see. R11 stated there was a fire in R11's room and R11 could smell the smoke. R11 stated, I was scared.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R11 is a [AGE] year-old female admitted to the facility 11/17/16 with diagnosis included but not limited to End Stage Renal Disease, Dependence On Renal Dialysis, Chronic Obstructive Pulmonary Disease, Legal Blindness As Defined In USA, Type 2 Diabetes Mellitus, Cerebral Infarction, Protein Calorie Malnutrition, Hemiplegia and Hemiparesis Following Other Cerebral Vascular Disease Affecting Left Non-Dominant Side, Hypertension, Malignant Neoplasm Of Unspecified Kidney, Heart Failure, Primary Thrombophilia, Open Angle Glaucoma, Chronic Embolism And Thrombosis Of Unspecified Vein, Contracture Of Muscle Left Upper Arm, Dementia, Anemia In Chronic Kidney Disease. R11's MDS dated [DATE] documents in part, R11 is dependent for transfers and R11 does not use a wheelchair and/or scooter. R11's BIMS indicates R11 is cognitively intact.</p> <p>On 01/21/25 at 11:05 AM, V5 (Director of Maintenance) stated fire drills are conducted monthly on alternating shifts and all the facility fire pull stations are connected to a main fire panel located in the basement and this main fire panel is connected directly to the city emergency system. V5 stated anytime a fire alarm pull box is activated in the building the fire department should be notified automatically within seconds. V5 stated this is important because the fire department needs to be notified that there is a fire onsite, so they know to come to fight the fire for the safety of the residents and staff in the building. V5 stated we had a fire in a resident's room on 1/6/25 and staff was in the room when it happened. V5 stated the fire department said the fire was caused by a short in the electrical outlet on the wall which created a spark which then landed on the bedsheet and caught on fire. V5 stated the fire pull alarm on the unit was triggered by a staff but no alarm sounded, no lights were flashing, and the doors did not close. V5 stated someone called 911 to notify the fire department manually about the fire. V5 stated an outside vendor was called and came to the facility on [DATE] and found there was a short in the system and that is why the fire panel system did not trigger the fire department or sound the fire alarm in the building. V5 stated this outside vendor reset the system.</p> <p>On 01/21/25 at 12:12 PM, V9 (Licensed Practical Nursing) stated V9 was assigned to R8's room on 01/06/25 and that after dinner around 6:30 PM V9 heard a Certified Nursing Assistant yell, fire! V9 stated V9 entered the room and saw R8 sitting in R8's motorized wheelchair next to the bed and saw flames coming from R8's bed. V9 stated it looked like R8's mattress was on fire. V9 stated R10 was in R10's wheelchair exiting the room as V9 was entering the room and R11 was lying in bed near the window. V9 stated R8's wheelchair was not moveable and did not work. V9 stated it might have been that the wheelchair sparked the fire and V9 does not know if the wheelchair was plugged in or not. V9 stated V9 and V37 (Licensed Practical Nurse) transferred R8 into a geriatric chair as quickly as they could and R8 was brought down to the unit dining room. V9 stated the flames were close to R8 and if we had not removed R8 there is a potential that R8 could have been burned. V9 stated none of R8's clothing was burned. V9 stated V9 did a full body assessment and took vitals of R8 and R11. V9 stated V9 did not see any injuries on R8 but V9 noted R8 was scared. V9 stated R8 and R11's nurse practitioner (V49), family and V1 (Administrator) was notified and that they were not sent to the hospital. V9 stated everything happened all at once, and there was a lot of commotion. V9 stated V9 never heard any type of fire alarm sound or lights going on.</p> <p>On 01/21/25 at 1:10 PM, surveyor went with V5 to R8's room and viewed the location of the outlet. V5 stated the outlet was too far away from the bed to have caused the fire.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/21/25 at 1:30 PM, V5 (Director of Maintenance) stated he had made a mistake earlier and that the fire was caused by the R8's motorized wheelchair, not from a faulty electric outlet. V5 stated V5 does not know if the facility has a policy on wheelchair maintenance. V5 stated, I don't do any routine checks or monitoring on the electric wheelchairs because they are owned by the residents, not by the facility and if we do something to the electric wheelchair then we are liable, so it is not part of our responsibility. V5 stated V5 took R8's motorized wheelchair out of the room the night of the fire and V41 (R8's Son) came that same night and replaced a part. V5 stated V5 does not know what part V41 replaced or what R8's son did to the wheelchair.</p> <p>V5 provided document dated Fire Drill Evaluations dated 01/06/25 completed by V5 (Maintenance Director) documents in part, did the fire alarm strobe devices function properly? yes</p> <p>On 01/21/25 at 2:22pm V41 (R8's son) stated that he received a call from V9 (LPN) on 1/6/25 sometime in the evening but can't remember the specific time. He stated V9 told him that there was a fire in R8's room. V41 said as soon as he got the call he drove to the facility and was onsite within 5-10 minutes of receiving the phone call. V41 stated when he arrived, he saw a fire vehicle and a police car in front of the building. When he got up to the 3rd floor R8 was by the nursing station in a Geri chair. V41 said R8 was hysterical, and he could tell she was really scared and nervous. V41 said R8 was shaking her head back and forth and her eyes were big. V41 said he had to sit down to talk to V8 and try to calm her down. V41 stated R8's pillow, sheets and mattress were burned. V41 stated there were no burn marks on the wall but there were holes in the wall caused by R8 backing R8's motorized wheelchair into the wall. V41 stated there is a narrow space between the bed and the nightstand that R8's motorized wheelchair must fit into and so it is important that R8 has a little space on both sides of the wheelchair so that the electrical components of the motorized wheelchair do not scrape up against R8's bed frame. V41 stated R8's motorized wheelchair was still in the room after the fire and V41 could see that the fire department had pulled R8's wheelchair out from between the bed and the nightstand. V41 stated the fire department told V41 that the fire was started by the wheelchair. V41 stated V41 could see that the cord on the motorized wheelchair that connects to the controller on the left arm side of R8's wheelchair had exposed wires. V41 stated V41 could see a red and black wire which are normally contained and covered up by the plastic sheathing. V41 stated V41 thinks the cord that got caught up between the chair and the bed because the staff put the wheelchair too close to the bed and that the wheelchair rubbed up against the metal bed causing the cord to be shredded, thereby exposing the red and black wire, which must have created a spark. V41 stated V41 thinks it is that spark which caused the fire. V41 stated normally, the chair does not touch the bed and if it's touching the bed that means R8 is too close. V41 stated other damage to R8's wheelchair included a turn knob located on the back left side of the wheelchair which was melted to the point wherein all the knobs were no longer there. V41 stated that night V41 replaced the cord and secured it with zip ties. V41 stated on 1/5/25 prior to the fire V41 had replace the electronic charger for R8's motorized wheelchair. V41 stated V41 bought the motorized wheelchair for R8 in May 2024 and that V41 is the one who maintains R8's motorized wheelchair. V41 stated, I do all the repairs and maintenance checks on my mom's wheelchair. V41 stated V41 has experience fixing motorcycles so that is how V41 knows how to do the repairs on R8's motorized wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/21/25 at 2:50 PM, surveyor met with R8 and V41 (R8's Son) in R8's room. V41 showed the surveyor the melted knob on the back of R8's motorized wheelchair and stated there used to be 4 nubs on the knob but the fire burned them off and now there are none. V41 showed the area on the metal bed frame and stated, See? you can see the spots on the bed frame where the black plastic from the knob melted into clumps onto the bed frame. He said there were 3 black lumps which V41 proceeded to flick off 2 of the 3 spots. V41 also said you can see where the fibers of the plastic sheathing shredded and melted onto the bed frame. V41 then showed the surveyor photos on his cell phone that he took the night of the fire. The pictures showed that the mattress was burned on the side closest to the door/entrance of the room, and bed sheets/linens were charred black in the same area and that there were black charred areas on the bed frame in the same area of the melted plastic. V41 stated on 01/06/25 he could see that the cord on the motorized wheelchair that connects to the controller on the left arm side of R8's wheelchair had exposed wires. V41 stated he thinks the cord got caught up between the chair and the bed because the staff put the wheelchair too close to the bed and that the wheelchair rubbed up against the metal bed causing the cord to be shredded, thereby exposing the red and black wire, which must have created a spark. V41 stated that night V41 replaced the cord and secured it with zip ties.</p> <p>Surveyor requested for V41 to send copies of the photos to the email provided. State agency did not receive the photos via email provided on 1/21/24.</p> <p>On 1/22/25 at 11:45am V1 (Administrator) stated she arrived at the facility around 8:00pm on 1/6/25 and saw R8 who appeared scared surrounding the fire incident. V1 stated she spoke to the fire department staff and V1 stated she spoke with the Fire Investigator/Marshall directly and the Fire Marshall/Investigator stated there was nothing in the room which could have set the fire. V1 stated R8's doctor was notified and V1 asked R8 if R8 wanted to go to the hospital and R8 said no. V1 stated she did not do an investigation or report the incident to the state. V1 stated this fire incident was not reported to IDPH (Illinois Department of Health) because there was no injury and based on the facility's policy this incident was not considered to be an unusual occurrence and it did not need to be reported to IDPH. V1 stated none of the residents were sent to the hospital for evaluation.</p> <p>On 1/22/25 at 12:30pm, V38 (Housekeeper) stated V38 started working at the facility in 11/2024. V38 stated V38 was working on 01/06/25 downstairs in the basement cleaning the dialysis room when around 6:00-6:30 PM V38 stated heard a CODE RED announced overhead but V38 is not familiar with the code so V38 continued cleaning and mopping the dialysis room and did not go up to the unit. V38 stated after cleaning the dialysis room, V38 went up to unit about 15-20 minutes after the code red was announced. V38 stated that is when V38 saw ambulance people, fire people, policemen and residents in the dayroom.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/22/25 at 2:50 PM, V32 (Certification Nursing Assistant) stated V32 was walking by R8, R10 and R11's room on 01/06/25 and heard someone saying fire, fire. V32 stated V32 could see flames from the hallway, and it looked like the fire was coming from R8's bed. V32 stated the curtain and the side of R8's mattress was in flames. V32 stated R8 was sitting in R8's motorized wheelchair next to R8's bed which was on fire. V32 stated V32 pushed the mattress away and pulled the privacy curtain away from R8 to try to get R8 away from the flames but could not move R8's motorized wheelchair. V32 assisted R10 out of the room and then went to the nursing station to alert the nurses about the fire. V32 stated V32 went back into the room to retrieve R11, unlocked R11's bed and as V32 was leaving the room with R11, V32 observed two EMT (Emergency Medical Technicians) entering the room. V32 saw the two EMTs grab R8 from R8's motorized wheelchair using sheets and transferred R8 into the geriatric chair.</p> <p>On 01/22/25 at 2:01 PM, via phone interview V46 (Registered Nurse) stated V46 was working on 01/06/25 and sitting at the nursing station when V32 (CNA) walked to the nursing station and said, there is a fire. V46 stated V46 could already see smoke in the hallway and when V46 entered the room, V46 saw R8's bed on fire and R8 was sitting in R8's motorized wheelchair which was right next to the fire. V46 stated V46 could smell burning rubber and saw a white extension cord on the floor which was melted. V46 stated that morning R8's wheelchair was not working correctly and that evening the staff was charging the wheelchair using a white extension cord. V46 stated the smoke and fire alarm did not go off in the room or hallway or the rest of the building so, initially none of the staff knew that there was a fire in the building. V46 stated R8's motorized wheelchair would not move so; we were trying to figure out the best way to move R8. V46 stated there were two EMTs (Emergency Medical Technicians) on the floor because they had just delivered a resident to the floor from the hospital and the EMTs are the ones who [NAME] into action. V46 stated one EMT and the CNA (V32) wrapped R8 in a blanket and transferred R8 into a geriatric chair. V46 stated V46 told someone to make an overhead page to alert the other staff that there was a fire in the building because we needed help removing the residents away from the fire. V46 stated one of the other nurses was directing the other EMT on where to get the fire extinguisher and that is when V46 called 911 right there from the room from V46's personal cell phone because V46 stated the fire didn't stop, it was growing and getting bigger. V46 stated V46 was getting scared. V46 stated then V46 saw the other EMT use the fire extinguisher to put out the fire. V46 stated after the fire was put out it was very smokey in the hallways and in R8's room. V46 stated the fire department who came told the staff that it was an electrical fire cause by the extension cord or motorized wheelchair.</p> <p>On 01/22/25, V11 (Evening Nursing Supervisor, Licensed Practical Nurse) stated after the fire V11 could see cords hanging on the back of the wheelchair and you could tell that someone had tried to fix it because there was black electric tape on the cord, and it was hanging from the wire. V11 stated there was no alarm going off on the floor or anywhere else in the building and there should have been because the fire alarm sound is needed to alert everyone that there is an active fire going on.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/22/25, V11 (Evening Nursing Supervisor, Licensed Practical Nurse) stated on 01/06/25 at 6:50 PM, V11 was taking a break in V11's office on the 1st floor when V11 received a cell phone call from V9 (LPN) notifying V11 that there was a fire on the floor. V11 stated, I asked her, a real fire? And V9 replied, yeah! V11 stated V11 did not hear any type of fire alarm sounding in the building. V11 stated V11 left V11's office immediately and went passed the receptionist and told the receptionist to announce CODE RED overhead. V11 stated by the time V11 arrived on the unit there was no active fire, only a lot of smoke. V11 stated there were no residents in the room. V11 stated R8's motorized wheelchair was in the hallway and V11 could see cords hanging on the back of the wheelchair. V11 stated you could tell that someone had tried to fix it because there was black electric tape on the cord, and it was hanging from the wire. V11 stated there was no alarm going off on the floor or anywhere else in the building and there should have been because the fire alarm sound is needed to alert everyone that there is an active fire going on.</p> <p>On 01/24/25 at 9:48 AM, V2 (Director of Nursing) stated she was not onsite at the time of the fire. V2 stated all three residents should have been assessed by a nurse that night since they were all in the room at the time of the fire and exposed to the smoke. V2 stated a fire is an unusual event and since it was an unusual event the nurses would need to monitor the residents regularly to make sure they are okay. V2 stated this monitoring should be done every shift for the following 72 hours after the fire by the nurse on duty and documented under the assessments tab listed under skin assessments. With surveyor V2 reviewed R8's EHR (Electronic Health Record) and stated R8 does not have any 72-hour nursing assessments completed after the fire on 01/06/25 but should. V2 reviewed R10 and R11's EHR and verbalized that there are some 72-hour nursing assessments missing and not all the shifts were done.</p> <p>On 01/24/25 at 10:30 AM, observed R8 lying in bed and R8's motorized wheelchair next to R8's bed. V48 (Day Nurse Manager/Licensed Practical Nurse) stated R8's motorized wheelchair was not working. V48 stated, we are trying to figure it out. It won't move. It was on the charger, but it won't turn on. When we press the button to turn it on, it turns right off and I'm going to call the son so he knows it's not working and can fix it.</p> <p>Surveyor observed white sticker on R8's motorized wheelchair for Pride Mobility and listed a web site.</p> <p>On 01/24/25 at 11:40, V5 (Director of Maintenance) stated the nurses told V5 that R8's wheelchair was not working. V5 stated V5 took off the cover on the wheelchair and moved some of the wires around and replaced the cover and it turned back on.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Ryze West		STREET ADDRESS, CITY, STATE, ZIP CODE  5130 West Jackson Boulevard Chicago, IL 60644	
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/24/25 at 11:54 AM, was interviewed further about the fire incident and her chair not working. R8 indicated by nodding R8's head up and down in a yes motion that there was a fire in R8's room when R8 was sitting in R8's motorized wheelchair. R8 nodded and gestured that the fire was coming from the back left side of R8's wheelchair. R8 gestured to the left side of R8 wheelchair when asked if R8 felt hotness from flames and motioned up and down R8's left arm. R8 indicated that R8 was still using the same motorized wheelchair that was involved in the fire and that it wasn't working again today. R8 indicated by nodding R8's head up and down in a yes motion when R8 was asked if she scared during the fire and if R8 is still scared. R8 appeared to display wide open eyes, raised and furrowed eyebrows, while communicating about the fires R8 gestured and responded no, when R8 was asked if R8 needed to go to the hospital on 1/6/25. R8 indicated that if someone had asked R8 if R8 wanted to go to the hospital the night of 1/6/25, R8 would have said yes, because R8 wanted to be checked after the fire incident.</p> <p>On 01/24/25 at 11:04 AM, V49 (R8 and R11's Nurse Practitioner) stated V49 was called by V9 on the evening of 01/06/25 and was made aware of the fire that occurred. V49 stated V49 was told there was a localized fire in the room and all the residents had been removed from the room. V49 stated V49 takes care of R8 and R11, not R10. V49 stated V49 was aware that R8 and R11 was exposed to fire and smoke. V49 stated V49 was told the fire was caused by R8's motorized wheelchair and that R8 was sitting in the wheelchair when the fire broke out and R11 was also in the room. V49 stated based on what was communicated to V49 there was a fire, and R8 was evacuated, and R8 had no clinical symptoms of smoke inhalation and no burns. V49 stated R8 was the focus of the phone conversation, not R11. V49 stated V49 she was not made aware of the fire alarm system not working. V49 stated if V49 had known that V49's clinical judgment could have been potentially different, but V49 still does not know if V49 would have sent R8 or R11 to the hospital. V49 stated if the fire alarm did not sound this could potential have caused a delay in staff response and longer resident exposure to the fire and smoke. V49 stated it is possible to have smoke inhalation without having overt clinical symptoms.</p> <p>On 01/24/25 at 1:05 PM, V53 (Vice President of Operations for [NAME] Health Care) stated R8's motorized wheelchair is what caused the fire. V53 stated the son helps R8 with the wheelchair and the wheelchair was removed and repaired by the son. V53 stated the facility does not do any repairs because the wheelchair is not owned by the facility. V53 provided the survey team with a printed documents from the facility's internal [NAME] Management portal. It was labeled in part, #1742 other, the date and time was not visible on the top portion of the document. V8's name was also on the top of the 5 pages provided. R10 and R11 were not listed. V53 also provided survey team a printed copy of the Manufacturers Guide for Pride Mobility Motorized Wheelchair for R8.</p> <p>Document titled Pride Mobility Owner's Manual which documents in part, under no circumstances should you modify, add, remove, or disable any feature, part or function of your power chair and do not modify your power chair in any way not authorized by Pride and if you discover a problem, contact your authorized Pride Provider for assistance. General Guidelines include but not limited to avoid knocking or bumping the controller and avoid prolonged exposure of your power chair to extreme conditions, such as heat. Daily, weekly, monthly, and yearly checks listed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/27/25 at 2:13 PM, via phone interview V52 (Service Telephone Support Pride Mobility for R8's Motorized Wheelchair) stated if a Pride motorized wheelchair was involved in a fire and/or within close proximity to a fire, exposed to high temperatures it should be evaluated by an authorized licensed Pride Technician before putting it back in use. V52 stated this is a safety precaution in case anything externally and/or internally got burned or damaged. V52 stated you may not be able to see the defect and it might not be safe for use and should be evaluated by a licensed authorized Pride Technician. V52 stated all replacement parts must be ordered from Pride, be certified Pride parts and repairs should be scheduled through a dealer. V52 stated any parts ordered off internet could be defective and should not be used. V52 stated if non-Pride replacement parts are used this would null and void the warranty on the wheelchair as the dealer cannot ensure the safety of the wheelchair.</p> <p>On 01/29/25 at 9:31 AM, V56 (Director of Rehab/Occupational Therapist I've been working here for 2 years. I screen new admissions to see what they are here for, what they can/cannot do. If they cannot stand and/or transfer, then make a recommendation for them to use a wheelchair. V56 stated all residents who use motorized wheelchairs should be assessed by therapy to see if the resident can safety and independent maneuver the motorized wheelchair. V56 stated it would be important for them to be assessed for their safety and the safety of the other residents living in the facility. If they are on therapy the assessment would be in your documentation. If they are not on therapy, I use a screening sheet which I give to the Administrator. Unless there are concerns or something is brought to our attention by nursing, we don't reassess. The assumption is that the resident will maintain their level of function regarding using the motorized wheelchair safely and independently. We don't do any maintenance on the motorized wheelchair. If I notice any wires hanging, I'd notify the Maintenance Director. I never noticed any hanging wires from R8's motorized wheelchair before or after the fire.</p> <p>R8 is not on my case load but I am familiar with her. R8 uses a motorized wheelchair and I have seen her using it well - safely and independently. I did not evaluate her for the use of the motorized wheelchair. Recently, V1 or nursing had asked me to observe R8 usin [TRUNCATED]</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.</p> <p>47304</p> <p>Based on observation, interview, and record review, the facility failed to properly assess and implement interventions related to the psychosocial needs of one resident (R8) who was involved in and exposed to fire and smoke surrounding a fire related incident that occurred on 1/6/25 in R8's room. These failures resulted in R8 expressing emotional distress and fear after the incident.</p> <p>The findings include:</p> <p>R8's admission record showed admitted on 12/7/20 with diagnoses not limited to Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, Dysphagia oral phase, Anemia, Peripheral vascular disease, Absence epileptic syndrome, Other hereditary and idiopathic neuropathies, Encounter for attention to gastrostomy, Hyperlipidemia, Unspecified dementia, Chronic embolism and thrombosis, Gastro-esophageal reflux disease, Crohn's disease, Obstructive and reflux uropathy, Other sequelae of cerebral infarction, Type 2 diabetes mellitus with diabetic neuropathy, Aphasia, Essential (primary) hypertension, Heart failure, Major depressive disorder.</p> <p>MDS (Minimum Data Set) dated 11/14/25 reflects: R8's cognition was severely impaired. R8 needs partial/moderate assistance with oral hygiene, dependent with toileting hygiene, Substantial / maximal assistance with shower / bathe self, upper and lower body dressing, personal hygiene, chair / bed, and toilet transfer.</p> <p>On 1/21/25 At 12:05pm R8 was sitting up on a motorized wheelchair, alert, and responsive. R8 is non-verbal but able to make needs known by hand and head gestures. During interview R8 was able to recall the fire incident on 1/6/25, R8 nodded her head up and down, indicating yes when asked if she was involved and if she almost got burned. R8 then pointed to where the fire was and pointed and motioned to her left towards the arm and pointed at the back of the wheelchair. R8 then pointed the left side of her shoulder. R8 appeared scared and anxious. Surveyor then asked R8 were you scared? and R8 nodded her head up and down, indicating yes. Surveyor further asked are you still scared and R8 nodded her head again up and down, indicating yes and also appeared to become teary-eyed. Surveyor asked R8 if this was the wheelchair and R8 gestured to the chair and nodded her head up and down, indicating yes that she is still using the same motorized wheelchair. R8 also pointed to her bed. Surveyor observed that R8 was in the same room where the fire incident happened and noted dark brownish and black spots and markings on the side of the railing on R8's bed closest to the door. Surveyor also observed the footboard of R8s bed. The footboard appeared to have small charred circle like markings to the black strip at the top of the footboard, as well as melted portions to the black stripping at the top of the footboard.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/21/25 at 12:12pm V9 (Licensed Practical Nursing / LPN), stated she was assigned to R8's room on 1/6/25 and that after dinner around 6:30pm she heard a Certified Nursing Assistant / CNA yell, fire! V9 stated she entered the room and saw R8 sitting in her motorized wheelchair next to the bed and saw flames coming from R8's bed. V9 stated it looked like R8's mattress was on fire. She stated R8's wheelchair was not moveable and did not work. V9 stated it might have been that the wheelchair sparked the fire. V9 stated the flames were close to R8 and if R8 was not removed there was a potential that R8 could have been burned. V9 stated none of R8's clothing was burned. V9 stated she did a full body assessment and did not see any injuries but R8 was scared. V9 stated the nurse practitioner was notified and R8 was not sent out to the hospital. V9 stated R8 is non-verbal but alert, orientated and can understand what you are saying and will respond to yes/no questions.</p> <p>On 01/21/25 at 2:22pm V41 (R8's son) stated via phone interview that he received a call from V9 (LPN) on 1/6/25 sometime in the evening but can't remember the specific time. He stated V9 told him that there was a fire in R8's room. V41 said as soon as he got the call he drove to the facility and was onsite within 5-10 minutes of receiving the phone call. V41 stated when he arrived, he saw a fire vehicle and a police car in front of the building. When he got up to the 3rd floor R8 was by the nursing station in a Geri chair. V41 said R8 was hysterical and he could tell she was really scared and nervous. V41 said R8 was shaking her head back and forth and her eyes were big. V41 said he had to sit down to talk to V8 and try to calm her down.</p> <p>On 1/21/25 at 2:50pm V41 (R8's son) was in R8's room and showed the surveyor the melted knob on the back of R8's motorized wheelchair and stated there used to be 4 nubs on the knob but the fire burned them off and now there are none. V41 showed the area on the metal bed frame and stated, See?, you can see the spots on the bed frame where the black plastic from the knob melted into clumps onto the bed frame. He said there were 3 black lumps which V41 proceeded to flick off 2 of the 3 spots. V41 also said you can see where the fibers of the plastic sheathing shredded and melted onto the bed frame. V41 then showed the surveyor photos on his cell phone that he took the night of the fire. The pictures showed that the mattress was burned on the side closest to the door, and bed sheets/linens were charred black in the same area and that there were black charred areas on the bed frame in the same area of the melted plastic.</p> <p>Surveyor requested for V41 to send copies of the photos to the email provided. State agency did not receive the photos via email provided on 1/21/24.</p> <p>On 1/22/25 at 11:45am V1 (Administrator) stated she arrived at the facility around 8:00pm on 1/6/25 and saw R8 who appeared scared surrounding the fire incident.</p> <p>On 1/22/25 at 12:36pm V34 (Certified Nursing Assistant / CNA) stated she was working during the fire incident on 1/6/25. V34 said R8 was involved in the fire incident and looked distraught and scared out of her mind. V34 stated R8 is non-verbal but she can communicate with hand and head gestures. V34 said she knows R8 well and could tell R8 was shaken up by the whole experience. V34 said she asked R8 if she was scared, and she nodded her head up and down to indicate yes repeatedly. V34 said it gave her flashbacks herself (from a personal fire experience she was involved in) so she could understand how R8 was feeling. V34 stated R8 kept shaking her head from side to side as if R8 could not understand what had just happened, like R8 was in disbelief or shock.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/22/25 at 3:32pm V37 (LPN) stated she was working during the fire incident on 1/6/25 and R8 was shaken up and looked scared. V37 stated she asked R8, are you okay?, R8 shook her head no. V37 asked R8, Are you scared?, R8 shook her head yes.</p> <p>On 1/24/25 at 9:32am V8 ( Social Service Director/SSD ) stated their role includes mainly advocating for residents, checking, and monitoring psychosocial wellbeing and ensure documentation is done in a timely manner. He said SS (social service) department develop an individualized plan of care regarding resident's psychosocial wellbeing. V8 stated care plans would include goals and appropriate interventions in place to guide staff on how to care for the residents. V8 said care plans should be reviewed / revised at least quarterly and as needed to reflect the status and needs of the residents. V8 said psychosocial wellbeing includes emotions / feeling of the resident and Psychotherapy services are being offered in the facility. V8 stated he saw R8 the following day after the fire incident and R8 appeared scared and R8 was holding his hand very tightly. V8 said R8 being involved or experiencing the fire incident on 1/6/25 could be traumatizing to her because it is an unusual event. V8 said R8 should be checked /evaluated and monitored, provide with revisits, support/ reassurance and they ensure any psychosocial concern/issues are being addressed. R8's records were reviewed with V8. There was no documentation that interventions were provided to R8. V8 stated R8's psychosocial wellbeing and care plan should be reviewed / revised to reflect R8's status, any concerns and to evaluate appropriate interventions. V8 stated R8 could benefit with psychotherapy to discuss the fire incident that occurred on 1/6/25 to process her emotions.</p> <p>R8's progress notes from 1/6/25 to 1/14/25 were reviewed and no Social Service documentation was found.</p> <p>R8's care plan did not reflect that it was reviewed / revised to reflect R8's status after the fire incident on 1/6/25.</p> <p>On 01/24/25 at 9:48am V2 (Director of Nursing) stated she was not onsite at the time of the fire. V2 stated a fire is an unusual event and since it was an unusual event, the nurses would need to monitor the residents regularly to make sure they are okay. V2 stated this monitoring should be done every shift for the following 72 hours after the fire incident on 1/6/25 and document would be in resident's EHR (electronic health record). Surveyor reviewed R8's EHR with V2 and there was no documentation found that R8 was monitored 72 hours post fire incident.</p> <p>On 1/24/25 at 10:20AM V60 ( Licensed Clinical Social Worker / LCSW) stated she has been a contracted staff for the facility since March 2024. V60 stated she has been seeing R8 weekly due to diagnosis of MDD (Major Depressive Disorder) with symptoms of self-isolation in her room. V60 said she started seeing R8 in April 2024. She said R8 is alert and oriented x 4, nonverbal, and able to make needs known to staff using hand and head gestures. V60 said she was informed by facility staff that R8 was scared due to being exposed in a Fire incident on 1/6/25. She said she did see R8 on 1/14/25 and the fire incident was not directly discussed. V60 said V8's room change was the main topic of discussion. She said R8's involvement or exposure to fire and smoke incident is a traumatizing event. V60 said R8 could be helped on how to process her emotions by letting her express the traumatizing event. She said staff could provide reassurance that she is safe (presently) to help deal with anxiety that came with traumatic experience. V60 said she would not not recommend or be in favor for R8 to still used the same piece of equipment like the bed or chair with burn markings on it as it would possibly keep the trigger lasting. She said any little things could possibly trigger the traumatizing event.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R8's progress notes dated on 1/14/25 created by V60 (LCSW), documentation did not reflect psychotherapy session regarding fire incident on 1/6/25.</p> <p>On 1/24/25 at 11:15am V49 ( Nurse Practitioner/ NP) stated the fire incident on 1/6/25 could be a traumatizing event for R8 and she should have received psychotherapy to process her emotions and provide her with reassurance. V49 said the chair and bed could be a provocative cue and that using the same bed is not ideal. V49 said the facility should switch her bed as that could be triggering for R8.</p> <p>On 1/24/25 at 11:54 AM, was interviewed further about the fire incident and her chair not working. R8 indicated by nodding R8's head up and down in a yes motion that there was a fire in R8's room when R8 was sitting in R8's motorized wheelchair. R8 nodded and gestured that the fire was coming from the back left side of R8's wheelchair. R8 gestured to the left side of R8 wheelchair when asked if R8 felt hotness from flames and motioned up and down R8's left arm. R8 indicated that R8 was still using the same motorized wheelchair that was involved in the fire and that it wasn't working again today. R8 indicated by nodding R8's head up and down in a yes motion when R8 was asked if she scared during the fire and if R8 is still scared. R8 appeared to display wide open eyes, raised and furrowed eyebrows, while communicating about the fires R8 gestured and responded no, when R8 was asked if R8 needed to go to the hospital on 1/6/25. R8 indicated that if someone had asked R8 if R8 wanted to go to the hospital the night of 1/6/25, R8 would have said yes, because R8 wanted to be checked after the fire incident.</p> <p>On 1/30/25 At 10:26am V1 (Administrator) said the fire incident on 1/6/24 could be a traumatizing event for R8. V1 stated Social Services interventions could be utilized such as checking her mood, providing support, and should be documented. V1 said that during R8's Psychotherapy session, the fire incident could have been discussed to process her emotions. Surveyor requested facility's policy related to resident's psychosocial wellbeing, V1 stated facility does not have it.</p> <p>Facility's residents' rights policy dated 11/18 documented in part: Your rights to safety. The facility must provide services to keep your physical and mental health, at their highest practical levels.</p> <p>Facility's comprehensive care plan policy dated 1/2023 documented in part: The facility must develop a comprehensive person-centered care plan for each resident. The care plan will include a focus, measurable goal, and interventions specific to the resident's medical, mental, and psychosocial needs. The comprehensive care plan should drive the care and services provided for the resident and allow for the highest level of physical, mental, and psychosocial function. The comprehensive care plan should be reviewed with the resident and/or resident representative and changes made as appropriate.</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46342</p> <p>Based on observation, interview and record review, the facility failed to provide monthly surveillance and maintain patient care equipment, to ensure that it is in safe operating condition. This failure affected one (R8) out of five residents (R4, R8, R12, R13, R14) reviewed for preventative maintenance.</p> <p>Findings include:</p> <p>On 01/21/25 at 1:30 PM, V5 (Director of Maintenance) stated the fire was caused by the R8's motorized wheelchair. V5 stated he does not know if the facility has a policy on wheelchair maintenance. V5 stated, I don't do any routine checks or monitoring on the electric wheelchairs because they are owned by the residents, not by the facility and if we do something to the electric wheelchair then we are liable, so it is not part of our responsibility. V5 stated he took R8's motorized wheelchair out of the room the night of the fire and V41 (R8's Son) came that same night and replaced a part. V5 stated V5 does not know what part V41 replaced or what R8's son did to the wheelchair.</p> <p>On 1/21/25 at 2:22 PM, V41 (R8's Son) stated V41 he was called on 01/6/25 and drove to the facility that same night. V1 stated the fire department told him that the fire was started by the wheelchair, and he could see that the cord on the motorized wheelchair that connects to the controller on the left arm side of R8's wheelchair had exposed wires. V41 stated on 01/05/25, the day prior to the fire V41 had replace the electronic charger for R8's motorized wheelchair. V41 stated he is the one who maintains R8's motorized wheelchair. V41 stated, I do all the repairs and maintenance checks on my mom's wheelchair. V41 stated he has experience fixing motorcycles so that is how he knows how to do the repairs on R8's motorized wheelchair. V41 stated that night V41 replaced the cord and secured it with zip ties.</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/22/25 at 2:01 PM, via phone interview V46 (Registered Nurse) stated V46 was working on 01/06/25 and sitting at the nursing station when V32 (CNA) walked to the nursing station and said, there is a fire. V46 stated V46 could already see smoke in the hallway and when V46 entered the room, V46 saw R8's bed on fire and R8 was sitting in R8's motorized wheelchair which was right next to the fire. V46 stated V46 could smell burning rubber and saw a white extension cord on the floor which was melted. V46 stated that morning R8's wheelchair was not working correctly and that evening the staff was charging the wheelchair using a white extension cord. V46 stated the smoke and fire alarm did not go off in the room or hallway or the rest of the building so, initially none of the staff knew that there was a fire in the building. V46 stated R8's motorized wheelchair would not move so; we were trying to figure out the best way to move R8. V46 stated there were two EMTs (Emergency Medical Technicians) on the floor because they had just delivered a resident to the floor from the hospital and the EMTs are the ones who [NAME] into action. V46 stated one EMT and the CNA (V32) wrapped R8 in a blanket and transferred R8 into a geriatric chair. V46 stated V46 told someone to make an overhead page to alert the other staff that there was a fire in the building because we needed help removing the residents away from the fire. V46 stated one of the other nurses was directing the other EMT on where to get the fire extinguisher and that is when V46 called 911 right there from the room from V46's personal cell phone because V46 stated the fire didn't stop, it was growing and getting bigger. V46 stated V46 was getting scared. V46 stated then V46 saw the other EMT use the fire extinguisher to put out the fire. V46 stated after the fire was put out it was very smokey in the hallways and in R8's room. V46 stated the fire department who came told the staff that it was an electrical fire cause by the extension cord or the motorized wheelchair.</p> <p>On 01/22/25, V11 (Evening Nursing Supervisor, Licensed Practical Nurse) stated by the time V11 arrived on the unit there was no active fire, only a lot of smoke. V11 stated R8's motorized wheelchair was in the hallway and V11 could see cords hanging on the back of the wheelchair. V11 stated you could tell that someone had tried to fix it because there was black electric tape on the cord, and it was hanging from the wire.</p> <p>On 01/24/25 at 10:30 AM, observed R8 lying in bed with R8's motorized wheelchair next to her bed. V48 (Day Nurse Manager/Licensed Practical Nurse) stated R8's motorized wheelchair was not working. V48 stated, We are trying to figure it out. It won't move. It was on the charger, but it won't turn on. When we press the button to turn it on, it turns right off and I'm going to call the son so he knows it's not working and can fix it. Surveyor observed a white sticker on R8's motorized wheelchair for Pride Mobility and listed a web site.</p> <p>On 01/24/25 at 11:40 AM, V5 (Director of Maintenance) stated the nurses told him that R8's wheelchair was not working. V5 stated he took off the cover on the wheelchair and moved some of the wires around and replaced the cover and it turned back on.</p> <p>Chicago Fire Department Office of Fire Investigation Fire Marshall Report requested and obtained by the surveyor dated, 01/06/25 documents in part, there was no visible fire to the exterior of building; fire alarm system activated - no ; smoke detectors alerting - no ; after a thorough fire scene examination and evaluation it is the considered opinion that this fire incident was caused by the ignition of plastic wiring insulation from electrical energy, then spreading to immediately adjacent cloth/fabric combustibles in the form of bedding.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145661	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/05/2025
NAME OF PROVIDER OR SUPPLIER  Ryze West		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/24/25 at 12:24 PM, via phone interview V51 (Commanding Fire Marshall Deputy District Chief, Chicago Fire Department) stated V51 was not part of the team that responded to the fire on 01/06/25 but he spoke with the Fire Marshall who did respond, who said the fire appeared to be caused by an electrical issue. V51 stated V51 is looking at the Fire Marshall's Report of the incident on 01/6/25 and at pictures taken at the scene. V51 stated the pictures show that the cord in the back of the wheelchair is exposed and severed. V51 stated at one point the cord was one piece and the wires were contained inside the cord, but in the picture, there are two dangling pieces with exposed wires. V51 stated in V51's experience what happens is the cord containing the wires is subjected over time to physical damage either from getting banged, pinched, rubbed against, or perforated in some way. V51 stated the electricity heats up, melts the plastic and escapes from the plastic sheathing and now the electricity can jump and ignite any combustible material nearby. V51 stated in this case it appears the combustible material was the sheets and bed linens which acted as fuel for the fire. V51 stated this could be one of the causes of the fire based on what V51 is seeing in the pictures. V51 stated it is clear from looking at these pictures that the motorized wheelchair was involved in the fire but V51 cannot say definitively what caused the fire, but it appears it was from some type of electrical fire. V51 stated in V51's opinion this motorized wheelchair should be inspected by an electrical engineer before the resident is allowed to use it again. V51 stated It should not just be taped up and put back in service because we don't really know what happened and if there was an electrical event it may not be safe for the resident to continue using it. V51 stated the motorized wheelchair may be malfunctioning inside the wheelchair, but we cannot see it. V51 stated an electrical engineer should do an inspection to make sure the issue that potentially caused the first fire could not create another potential fire.</p> <p>On 01/27/25 at 2:13 PM, via phone interview V52 (Service Telephone Support Pride Mobility) stated if a Pride motorized wheelchair was involved in a fire and/or within proximity to a fire, exposed to high temperatures it should be evaluated by an authorized licensed Pride Technician before putting it back in use. V52 stated this is a safety precaution in case anything externally and/or internally got burned or damaged. V52 stated you may not be able to see the defect and it might not be safe for use and should be evaluated by a licensed authorized Pride Technician. V52 stated all replacement parts must be ordered from Pride, be certified Pride parts and repairs should be scheduled through a dealer. V52 stated any parts ordered off Amazon could be defective and should not be used. V52 stated if non-Pride replacement parts are used this would null and void the warranty on the wheelchair as the dealer cannot ensure the safety of the wheelchair.</p> <p>Document titled Pride Mobility Owner's Manual which documents in part, under no circumstances should you modify, add, remove, or disable any feature, part or function of your power chair and do not modify your power chair in any way not authorized by Pride and if you discover a problem, contact your authorized Pride Provider for assistance. General Guidelines include but not limited to avoid knocking or bumping the controller and avoid prolonged exposure of your power chair to extreme conditions, such as heat. Daily, weekly, monthly, and yearly checks listed.</p> <p>Facility provided policy titled, Preventative Maintenance Plan dated 1/2025 which documents in part, monthly surveillance of all resident rooms for any repairs needed and proper operation of all equipment. If a resident has personal equipment, it should be maintained according to manufacturer's guidelines.</p>		