

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 12/01/2025
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)		
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record reviews, the facility failed to ensure rehabilitation orders were followed for 1 (R1) out of three residents reviewed rehabilitation services, in a total sample of 3. Findings include: R1's Facesheet documents in part: R1 has a diagnosis of displaced intertrochanteric fracture of right femur. On 11/29/2025, surveyor did not observe any restorative aides assisting residents to walk on second and third floor. On 11/29/2025, at 11:07 AM, V2 (Director of Nursing) stated that she is familiar with R1. V2 stated that she was sent out because she had a high creatinine level. R1 was a hospital contract resident. V2 stated that because R1 was a hospital contract resident, they don't have any insurance. R1 does not have any insurance and physical therapy will not pick her up because she cannot pay for it. V2 stated that instead of physical therapy, restorative picked her up for therapy. V2 stated that while R1 was at the facility she would get 15 minutes a day of restorative therapy. That was all that was covered in her contract from the hospital. V2 stated that R1 was in a lot of pain so whatever she could tolerate that was what was done for her. V2 presented the restorative order for R1. V2 stated that she cannot find any documentation from restorative aides or CNAs carrying out the order. V2 stated that if it is not documented then it is not done. On 11/29/2025, at 12:15 PM, V4 (Restorative Nurse) stated that R1 was picked up for restorative. V4 stated that any restorative therapy that is done should be documented. If it is not documented, then it is not done. V4 stated that she has not worked on R1 expect for the initial evaluation. V4 stated that the certified nursing assistants should have worked with R1 during their daily activities of daily living care in order to prevent the decrease of range of motion. On 11/29/2025, at 12:36 AM, V1 (Administrator) stated that she vaguely remembers R1. V1 stated that R1 was only at the facility for a few days. She was supposed to get picked by restorative. V1 stated that R1 had a fall at home and sustained a femoral fracture. V1 stated that the restorative aides or certified nursing assistants are supposed to work with the residents according to the order that has been placed. V1 stated that if there is no documentation then technically the task was not done. Per R1's Face sheet, R1 was admitted on [DATE] and discharged on 9/26/2025. R1's physician order sheet documents in part: NURSING REHAB: Active ROM (Range of Motion) to upper and lower extremities on the left and right side, twenty times, for 15 minutes, five times weekly as tolerated. Reviewed R1's daily task audit report. No documentation of therapy from 09/20 to 09/24.		

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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