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	06/25/2026

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to prevent one resident at high risk for pressure ulcer development (R3) from acquiring a new facility acquired pressure ulcer and failed to order and perform a wound treatment to promote healing of R3's right buttock wound initially identified as a partial thickness wound/moisture associated skin damage (MASD). These failures affected one resident (R3) out of three residents reviewed for pressure ulcers. As a result of these failures, R3's right buttock wound progressed to a stage 3 pressure ulcer.Findings include:R3's medical diagnoses include but are not limited to pressure ulcer stage 3, muscle weakness, cognitive communication, and essential hypertension.R3's Minimum Data Set (MDS) dated [DATE] has a Brief Interview for Mental Status score of 13, indicating R3's cognition is intact.R3's MDS dated [DATE] section M for skin conditions documents in part, Number of stage 2 pressure ulcers 0. Number of stage 3 pressure ulcers 1.R3's progress note 06/23/26 titled Skin/Wound Note documents in part, Resident seen by wound care physician and wound care nurse for weekly wound assessment. Resident noted with an active Stage 4 pressure injury to sacrum. Resident also noted with a new non-pressure wound to the right lower buttock related to moisture associated skin damage. Wound measures 6.5cm (centimeters) by 4.2cm by 0.3cm.R3's document titled Wound Summary documents in part, Site: Right Buttock. Type: Pressure. Source: Facility Acquired. Identified by: V11Licensed Practical Nurse. Date: 06/25/26. Status: Active. Clinical Stage: Stage 2. Tissue Types: Blanchable Erythema 100% (percent). Date: 06/17/26. Status: Active. Clinical Stage: Stage 2. Tissue Types: Blanchable Erythema 100% (percent).On 06/25/26 at 9:58am surveyor observed R3's wound care dressing change. Observed R3 with wound to sacrum and wound to right buttock area. Right buttock wound observed to be a full thickness stage 3 wound with 10% white tissue adherent to wound bed and 90% granulation tissue and defined wound edges.On 06/25/26 at 10:13am V11 (Licensed Practical Nurse/LPN) stated that R3 is a high risk for skin breakdown due to R3's immobility, incontinence and prior history of pressure ulcers. V11 stated that she finds R3 soiled a lot. V11 stated that she is responsible for entering R3's physician's orders for wound care.On 06/25/26 at 12:18pm V11 (LPN) stated that initially R3's right buttock wound looked like a stage 2 pressure ulcer. V11 stated that a full thickness wound is considered a stage 3 wound. V11 stated that R3's right buttock wound is a full thickness wound and should have been documented as stage 3 and not stage 2. V11 stated that R3's right buttock wound is worse this week than when she first seen the wound a week ago. V11 stated that R3 is a high risk for pressure ulcers and due to R3's mobility, prior history of wounds and incontinence. V11 stated that R3's right buttock wound had not been documented before V11 documented R3's wound assessment on 06/17/26. V11 stated that she dropped the ball and did not enter R3's physician order for R3's right buttock wound. V11 stated that the documentation of R3's right buttock wound is incorrect. V11 stated that R3's wound bed tissue type is described as blanchable erythema, but R3's wound bed is open and is a full thickness wound. V11 stated that it is important for R3 to have wound care orders so that R3's wound won't be neglected and gets worse. On 06/25/26 at 12:41pm V2 (Director of Nursing/DON) stated that when a resident has an active wound there should be a physician's order for treatment of the wound. V2 stated that if the wound (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 0686 Level of Harm - Actual harm Residents Affected - Few	does not have an order and is not treated, the wound could get worse or infected. V2 stated that R3 should have had orders placed when R3's wound was identified. V2 stated that R3 should have had his care plan updated with new interventions when R3's new wound was discovered. V2 stated that the care plan would need new interventions because if R3 developed a new wound, that would mean the current interventions were not working.R3's care plan dated 05/13/26 documents in part, R3 has potential/at risk for alteration in skin integrity due to risk factors associated with . immobility, incontinence of bowel and bladder. R3 will have no complication thru next review date.Review of R3's care plan shows no new updates since new wound documented. Review of R3's physician's orders show no active wound care order for R3's right buttock wound that was identified on 06/17/26.Facility's policy titled Skin Care Prevention reviewed 09/2025 documents in part, General: All residents will receive appropriate care to decrease the risk of skin breakdown. Guidelines: 9. Clean skin at time of soiling and at routine intervals. 10. If incontinent, use a topical agent as a moisture barrier.Facility's resident's right pamphlet dated 11/18 documents in part, Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. You must not be abused, neglected, or exploited by anyone. The facility must provide services to keep your physical and mental health, at their highest practical levels.