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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 05/24/2024

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 0554

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Allow residents to self-administer drugs if determined clinically appropriate.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44103

Based on observation, interview, record review, the facility failed to follow their policy and procedure (a) to determine and assess a resident if self-administration of medications is appropriate; (b) to obtain a physician's order for medication self-administration; and (c) to implement a person-centered care plan addressing self-administration of medications for 1 (R124) out of 1 resident reviewed for self-administration of medications in the final sample of 35 residents.

Findings Include:

On 5/21/24 at 12:17 PM R124 was in R124's room. Surveyor noted wound dressings on top of R124's drawer. R124 stated that R124 has colon cancer and uses the dressings for R124's wound on R124's buttock. R124 opened R124's drawer and showed Surveyor the solution R124 uses for R124's wound. R124 stated that the wound care nurse gave the solution for R124 to use. R124 was unable to identify the wound care nurse. Surveyor also noted a bottle of Multivitamins in R124's drawer. R124 stated that R124 takes the multivitamin every morning.

On 5/22/24 AM at 10:20 AM, interviewed V2 (Director of Nursing) and stated that before letting the resident self-administer their own medications, the nurse must assess the resident if they are capable. They need to provide education and do return demonstration. V2 stated that the resident must have a doctor's order for medication self-administration and has to be able to do correct return demonstration. V2 stated that the resident must show and demonstrate the right way to administer the medication and the nurse should monitor them. V2 stated that in the resident's electronic health record, the resident should have documentation that education is provided for self-administration. V2 stated that if the resident requests to administer their own medication, the process is to complete the Medication Self-Evaluation Administration Assessment and if the resident is capable to self-administer their own medications, order is obtained from the doctor, education is provided with correct return demonstration from the resident, and it should be addressed in the care plan. Surveyor checked R124's electronic health records with V2 and no documentation showing R124 was assessed to determine if R124 is capable of administering R124's own medication, no documentation if education was provided for medication self-administration, no order obtained from the physician and no care plan addressing R124's medication self-administration.

(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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R124's electronic health records show an admitted [DATE] with diagnoses not limited to Auditory Hallucinations, Major Depressive Disorder, Mild Cognitive Impairment, Malignant Neoplasm of Colon, and Malignant Neoplasm of Anal Canal. R124's physician orders with active orders as of 5/22/24 shows no order for medication self-administration. R124 has orders for Dakins Solution to apply to buttocks topically for wound treatment and Multivitamin with Minerals one time a day. R124's Minimum Data Set, dated dated dated [DATE] shows R124 is cognitively intact. R124's care plan does not address if R124 if medication self-administration is appropriate for R124. The facility's policy titled; SELF ADMINISTRATION OF MEDICATIONS AND TREATMENTS dated 1/2024 reads in part: GUIDELINE: 1. Self administration of medications and treatments is determined by an order after determining that the resident is able to self administer. PROCEDURE: 1. If it is determined by a member of the interdisciplinary team, or if the resident requests to self administer, it is documented in the chart and the Health Care Provider is called for an order to self administer medications, and keep the medications at bedside. 2. Determination of the ability to self-administer medications will be done by nursing using the form in PCC titled Medication Self-Evaluation Administration. 7. A care plan is for resident who self administer, and documentation should be present in the nursing notes of teaching to self administration of the medications or treatments.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50057 Based on observation, interview and record review, facility failed to provide an adequate supply of linens to meet staff and resident needs in the provision of resident care. This failure has the potential to affect all 180 residents of the facility. Findings: On 5/21/2024 at 2:30 PM observed three CNAs (certified nursing assistant) carts on the 2nd floor. No bath towels were observed on any of the three carts. On 5/21/2024 at 2:35 PM, V9 (CNA) was interviewed. V9 stated that the CNAs start the shift with a linen cart that each CNA puts together. Linens are brought up by the laundry room and put in an alcove in the hallway. Each resident uses three towels to shower or bathe so V9 stated that the staff go through towels quickly. Once the towels are gone, V9 stated that staff call the laundry room to get more. Our shift is over at 3, so there are no towels on the floor. The laundry room will bring new linens for the 3-11 shift. Laundry bring the cart each shift. V9 stated that they sometimes have to wait for linens to come up to the floor. On 5/21/2024 at 3:25 PM V30 (Laundry Aide) was interviewed and stated that linen carts go up to the floors at the start of each shift. Staff come down if they run out of linens during a shift. Staff have to wait to get linens if the laundry has accumulated and linens are not yet clean. I have to clean, dry and sort the linens so staff do run out at times. On 5/22/2024 at 12:15 PM V29 (Laundry Aide) was interviewed and stated that the Daily Linen Delivery chart documents the linen that is sent in three carts (one per floor) for each shift. Par levels are listed on the document. V29 stated that she was not sure what the par levels meant. V29 stated that the laundry aide writes down how much linen is sent to the floor each shift. V29 stated For example, if we write twenty-one bath towels on the sheet, that means that we sent seven bath towels to the second floor, seven bath towels to the third floor, and seven bath towels to the fourth floor. On 5/22/2024 at 12:28 PM V32 (Division Manager Laundry Services) was interviewed and stated that that clean laundry is sent to each floor each shift at 7 AM, 3 PM and 11 PM. V32 stated that the laundry room does not send linens up to the floors at 12 PM. V32 stated that laundry aides should be stocking the linen carts to the par levels. V32 reviewed the document Daily Linen Delivery and stated that the par levels on the sheet were outdated. There should be three bath towels for each resident each shift. For example, if there are two hundred residents, there should be three bath towels sent up for each resident which would total six hundred bath towels (two hundred for each floor) plus some overage for accidents. The par level on the Daily Linen Delivery document says sixty bath towels each shift. V32 stated that the laundry room does not always get linens to wash because the staff do not send them down or the staff throw away linen. We see linens come down as garbage. When asked if there is enough linen in the building, V32 stated I don't think so. V32 stated I have text messages and pictures that I have sent to V1 (Administrator). We don't have enough extra linens on hand. V32 stated that she keeps additional linen stock and the laundry aides know to come to her office to get what they need to get to par level. V32 stated However, the facility does not have bath towels. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/22/2024 at 12:45 PM, the linen overstock area was observed with V32 (Division Manager Laundry Services) . V32 stated, and surveyor observed, that there are flat sheets, fitted sheets and washcloths available. There were no bath towels available in the overstock area. On 5/22/2024 at 1:00 PM, the Daily Linen Delivery documents for May 15, 2024 at 7 AM through May 22, 2024 at 7 AM were reviewed. These documents provide the par levels (minimum count) for linen items for each shift and then the number of actual items that we sent to the floors each shift and this document states the facility did not meet minimum count of [NAME] for resident care. On 5/22/2024 at 1:15 PM Concerns about substandard quality of care was discussed with V1 (Administrator). Findings of Daily Linen Delivery logs were discussed, and plan of correction was requested. On 5/22/2024 at 1:44 PM V1 (Administrator) stated that she had ordered linens and spoken to a sister facility who was sending linens to the facility today. On 5/22/2025 at 2:51 PM V1 (Administrator) stated that 300 wash clothes and 98 bath towels had arrived from a sister facility. An additional four hundred and fifty-six bath towels were ordered and four hundred and fifty six wash clothes were ordered and are due to arrive at the facility on Saturday, May 25, 2024. On 5/23/2024 at 9:18 AM V37 (CNA) stated that there are no bath towels on the 2nd floor. On 5/23/2024 at 9:27 AM V28 (CNA) stated that there are 20 bath towels and 45 wash clothes on the 3rd floor. V28 stated that residents will use two to three towels to shower or have a bath. Sometimes we are stocked with linens. Sometimes we are not. V28 explained that residents hide towels because when they need one, they can't get it. On 5/23/2024 at 9:32 AM, V38 (CNA) stated that there were 22 bath towels and 45 wash clothes on the fourth floor. V38 stated that he had fifteen residents assigned to him. There are five CNAs on the unit and each have approximately fifteen residents assigned to them. Each resident will use one or two bath towels during the shift and one or two wash clothes. On 5/23/2024 at 9:48 AM, V1 (Administrator) was made aware that the second floor had no bath towels at 9:18 AM, third floor had twenty bath towels and forth floor had twenty-two bath towels. V1 stated We just added towels yesterday. I will call V32 (Director Laundry Services). RESIDENTS ' RIGHTS LONG-TERM CARE OMBUDSMAN PROGRAM booklet documents in part: Your facility must be safe, clean, comfortable and homelike.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 39779 Based on observations and interviews, and record review the facility failed to repair a hole in the ceiling and replace the missing/stained ceiling tiles in the first-floor dining room and failed to maintain the walls in the residents' rooms in good repair for 3 (R114,R86, R58) residents in a sample of 35. Findings Included: During the facility tour of the first-floor dining room on 05/21/24 at 09:16 AM a missing ceiling tile was observed at the west end of the dining room and 4 ceiling tiles with brown stains. The ceiling that was observed above the missing tile was peeling. There was a large yellow garbage can positioned near the area of the missing tile with what appeared to have water in it. On 05/21/24 at 11:25 AM R112 was observed sitting in the first-floor dining room. When asked by the surveyor does the ceiling leak in the dining room R112 responded water leaks from the ceiling and it bothers me to see the water. They know about it and have not done anything. On 05/21/24 at 11:34 AM R137 was observed in the first-floor dining room. R137 stated I got on maintenance about the holes in the walls. You see that (referring to and pointing at the missing ceiling tile in the first-floor dining room). Don't you see the brown spots on the ceiling tiles. Don't you see the ceiling peeling where the ceiling tile is missing. That problem needs to be taken care of. On 05/21/24 at 11:39 AM surveyor entered R114's room and observed the baseboard at the head of Bed C bed missing with a hole along the base of the wall. 05/23/24 at 10:06 AM V36 (Maintenance Director) stated I started working here on 01/28/24. If they tell me that there is a hole in the wall I go and fix it. This building has been neglected for years. We are going floor by floor and room by room to fix things. Lots of the furniture is broken down that I have started fixing and changing things. There are only two maintenance people in the facility. During the facility tour at 10:10 AM in the first-floor dining room there was a missing ceiling tile with peeling plaster with a hole and ceiling tiles with brown stains near the west wall with a large yellow bucket that appears to have water in it. V36 stated that just got fixed on Thursday When asked why the missing ceiling tile and the ceiling tiles with the brown stains were not replaced. V36 responded the tiles were wet. There were 7 leaks in the facility. Surveyor asked V36 was the large yellow bucket used to catch the water that was leaking from the ceiling, V36 responded yes. I will have the ceiling tiles replaced within two hours. On 05/23/24 at 10:16 AM surveyor entered R114 room with V36 (Maintenance Director) and observed a hole at the base of the wall at the head of the bed measuring approximately 24 inches x 4 inches. V36 stated that need to be calked and put together. We started making repairs on the third floor. V36 opened the bathroom door and stated I need to cut the wall and replace the dry wall. That is from water damage and the bed being pushed up against the wall. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/23/24 at 10:16 AM surveyor entered R86's room with V36 (Maintenance Director) and observed the dry wall loose and able to be pushed in with a hole approximately 3 inches x 2 inches above the baseboard to the right near the room entrance. V36 stated that has to be fixed. On 05/23/24 at 10:26 AM surveyor entered room R58 with V36 (Maintenance Director) and observed a hole at the bottom of the wall at the head of R58's bed measuring approximately 9 inches x 4 inches. V36 stated that hole is from the bed being pushed up against the wall. Worked order dated 03/21/24 document in part: R86's room issue: the walls are in very bad shape paint and plaster chipping badly. Policy: Titled Preventive Maintenance Plan reviewed 01/24 document in part: To provide the staff with guidance on preventive maintenance within the facility. Proof of inspections will be recorded in the electronic TELS system or on paper tracker provided. 6. All resident rooms should be inspected for any repairs needed and proper operation of all equipment. Titled Maintenance Director undated document in part: Summary: The primary purpose of the Maintenance Director is to plan, develop, and direct the overall operation of the Maintenance Department in accordance with current, federal, state, and local standards, guidelines, and regulations governing our facility, and as may be directed by the administrator, to assure that our facility is maintained in a safe and comfortable manner. Essential Duties and Responsibilities: Repair facility/resident property as necessary. In the event of inability to repair coordinate with outside vendors to make repair or replace as cost effectively as possible. Ensure that supplies, equipment, etc., are maintained to provide safe and comfortable environment. Make weekly inspections of all maintenance functions to assure that quality control measures are continually maintained.

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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. 50057 Based on observation, interview, record review facility failed to follow facility policy in reporting an abuse and neglect allegation by one resident (R23) out of a total of 35 residents in the sample. Findings On 05/21/24 at 9:18 AM, R23 approached surveyor and asked Are you with the state? R23 stated They are stealing my money and stuff. R23 stated that she told the administrator. V13 (LPN) approached surveyor and R23 and stated It hasn't reached us yet. Surveyor repeated to V13 R23's statement that They are stealing my money and stuff. R23 stated They also neglect me a lot. They bully people. (V13 did not report the allegation to V1 Administrator) On 05/22/24 at 10:40 AM, V1 (Administrator) was interviewed about the facilities abuse allegation and reporting process. V1 stated that when a resident alleges abuse, V1 is the first person notified. If the allegation is staff-to-resident, the staff member is sent home, resident is sent to the hospital if necessary, and police are called. V1 stated that she then does her investigation. V1 talks to the resident and other residents who may have been witness to the event. V1 also talks to the resident to make sure that the resident feels safe. V1 talks to staff and gets as much detail about the allegation as needed. V1 stated that accusation of stealing money or property falls under the definition of abuse. V1 stated that staff do not take into account the psychiatric state of the resident when deciding if they should report an abuse allegation. They report all abuse. V1 stated that all staff have her phone number. V1 stated that there should be no staff member that says that a resident compliant of stolen money or property or bullying or neglect is not brought to my attention. V1 was asked about R23 and stated that she was not aware of any recent allegations of abuse by R23. V1 was asked what the timeframe for reporting an allegation was. V1 stated that the staff report an allegation to her immediately and then V1 reports the allegation to the state within 24 hours. When V1 was told that R23 made an allegation of stolen money and property and bullying on 5/21/2024 at 9:18 AM, V1 said I was not aware. When V1 was asked if staff should have reported the 5/21/2024 allegation to V1, V1 stated yes. I will investigate. I will report it. On 05/22/24 at 11:10 AM V1 (Administrator) and surveyor met with R23. R23 stated to V1 that she was missing money and also did not get her check. R23 stated that staff bully her. It happened today. V1 asked if resident felt safe. Initially R23 stated yes. On 5/23/2024 at 1:52 PM, V1 (Administrator) provided Facility Reported Incident documentation of R23's allegation. Form was submitted 5/22/2024 at 5:10 PM. Policy titled Abuse Policy and Prevention Program 10/2022 states in part: V. Internal Reporting Requirements and Identification of Allegations (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property that they observe, hear about, or suspect to the administrator immediately to an immediate supervisor who must then immediately report it to the administrator or compliance officer. Any allegation of abuse or any incident that results in serious bodily injury will be reported to the Illinois Department of Public Health immediately, but not more than two house after the allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within twenty-four hours.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 46342 Based on interview and record review, the facility failed to refer one resident (R3) to the appropriate state designated authority for a Level II Preadmission Screening and Resident Review (PASARR) evaluation out of 5 residents reviewed for PASARR in a total sample of 35. Findings include: R3's OBRA - Initial Screen (Identification for Individuals for Whom There is a Reasonable Basis to Suspect a Developmental Disability or a Mental Illness) completed by state-designated authority dated 11/15/28 documents in part based upon all information and data available to me for this person there is a reasonable basis for suspecting DD (Developmental Delay) or MI (Mental Illness) with the no box checked. R3's diagnosis includes but not limited to Unspecified Dementia, Anxiety Disorder, Major Depressive Disorder, Bipolar Disorder, and Restlessness and Agitation. On 05/23/24 at 1:24 PM, V16 (Social Service Director) stated PASARR level I screen is completed prior to admission and depending on the residents added diagnosis and behaviors the facility then requests a PASARR level II assessment. V16 stated diagnosis requiring PASARR level II assessment include dementia, severe mental health diagnosis such as schizophrenia, Schizoaffective Disorder, Depression, Bipolar Disorder, Anxiety, and Major Depressive Disorder. V16 stated the PASARR level II assessment are request and completed within 48 hours of request by an outside agency. V16 stated the PASARR level II evaluation has a score that determines the resident's cognitive ability, mental health needs and tells the facility whether or not the resident is appropriate to stay in the facility, so the PASARR level II is important because the residents need a certain score to determine if this nursing home is the appropriate setting for that resident based on the level of care and services they need. V16 stated for residents who have been living at the facility for an extended period social service are supposed to update the PASARR for residents annually. V16 stated they are in the process of doing an audit to find out who needs PASARR level II assessments. V16 stated V16 submitted a request for R3 to be evaluated on 05/22/24 PASARR level I screen and it was determined that PASARR level II assessment is needed onsite based on R3's diagnosis of mental illnesses. V16 stated V16 submitted PASARR level I screen yesterday because I wasn't aware he (R3) needed a level II until you asked me for it. Facility provide document titled, Notice of PASRR Level I Screen Outcome reported date 05/22/24 documents in part, R3's reason for screening: This nursing facility resident has never had a PASRR level I screen and refer to level I onside, suspect or confirmed PASRR conditions: Mental Health Disability. PASRR Outcome Explanation Notice of PASRR Level II Onside Evaluation Required which documents in part our health care professional completed Preadmission Screening and Resident Review (PASRR) level I screen for you and this screen shows that you need a face-to-face level II evaluation. PASRR level I screen and level II evaluations are required by Federal Law, 42 U.S.C. 1396r(e)(7). Facility provided policy titled PAS Screening dated 1/2024 which documents in part, (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in accordance with Illinois regulatory standards and recommended practices, this organization requests Level 1 (one) and Level 2 (two, where applicable) Pre-Admission Screening documents prior to the individual's arrival at the facility and it is the policy of this facility to comply with Illinois standards addressing the PAS assessment/screening process.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47304 Based on observation, interview, and record review, the facility failed to (a) provide the necessary care and services to ensure that one (R92) resident was assisted or supervised with personal hygiene / shaving and (b) follow facility policy and standards of professional practice in providing care and communication in one resident's (R179) primary language. These failures affected two (R92 and R179) residents reviewed for activities of daily living (ADL) in a sample of 35. The findings include: R92's health record documented admitted on 2/16/2019 with diagnoses not limited to Alcohol dependence with withdrawal, Esophagitis, Thrombocytopenia, Gastro-esophageal reflux disease with esophagitis, Constipation, Personal history of covid-19, Age-related nuclear cataract bilateral, Tension-type headache, Vitamin d deficiency, Insomnia due to medical condition, Decreased white blood cell count, Spinal stenosis cervical region, Nontraumatic intracerebral hemorrhage, Cervicalgia, Dysphagia following other cerebrovascular disease, Traumatic hemorrhage of cerebrum, Unspecified cirrhosis of liver, Nicotine dependence, Encounter for attention to gastrostomy, Essential (primary) hypertension, Bipolar disorder, Post-traumatic hydrocephalus, Iron deficiency anemia, Presence of cerebrospinal fluid drainage device, Chronic viral hepatitis c. On 5/21/24 at 10:45 AM R92 observed lying in bed, alert and oriented x 3, verbally responsive. Observed with long beard more than 5inches. Stated he can have staff assist him with shaving. He said staff did not offer or assist him with shaving. He said he does not have working shaver. At 11:19 AM Requested V3 (LPN / Licensed Practical Nurse, Restorative Nurse) to R92's room and R92 stated he wanted his beard shaved off. R92 said beard is about 5-6 inches long and he wanted to take off everything. R92 said I have more beard than my actual hair. At 12:20 PM V4 (Certified Nursing Assistant / CNA) said she has been working in the facility for [AGE] years. Stated she is assigned to R92. She said residents are assisted or supervised with activities of daily living (ADL) such as washing face, clipping nails, toileting needs, personal hygiene, grooming, shaving, bathing / showering. She said shaving is done or offered to resident at least every other week or as needed. Shower is provided 2x per week. She said R92 is ambulatory with walker, needed limited assistance or supervision with most of his ADLs. She said R92 needed assistance or supervision with personal hygiene or shaving. She said she did not offer to shave R92 and was not told that he wanted to be shaved. On 5/22/24 at 10:52 AM V2 (Director of Nursing / DON) stated all residents should receive ADL care including grooming, toileting, personal hygiene / shaving. Staff are expected to assist or supervise residents with ADL care and should be documented if provided or refused. She said staff is expected to assist resident with shaving for hygienic purposes. MDS dated [DATE] showed cognition is moderately impaired. Needed set up/clean up assistance with eating, oral hygiene; Supervision / touching assistance with toileting and personal hygiene, shower / bathe self and upper and lower body dressing, chair / bed and toilet transfer. (continued on next page)

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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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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Care plan dated 2/22/22 documented in part: R92 has an ADL self-care performance deficit. Care plan interventions included but not limited to Personal hygiene: R92 requires supervision to limited assistance x 1 staff participation with personal hygiene. Facility's policy for activities of daily living dated 2/2023 documented in part: - The ability of each resident to meet the demands of daily living is determed by a licensed nurse. - A program of assistance and instruction in ADL skills is care planned and implemented. - Resident's facial hair should be shaved if necessary and appropriate per personal preference. 50057 On 05/21/24 11:13 AM R179 stated No hablo [NAME]. V13 (LPN) was asked how staff communicate with R179. V13 stated that R179 points to what he wants. V13 initially stated that there was no other way to communicate with R179, but then stated There is also an app that we can use. V13 stated that V9 (CNA) was assigned to R179. V9 stated He speaks English. V9 entered R179's room and asked R179 if he wanted to shower. V9 stated He understands what we are saying. When asked how staff allow R179 to communicate back to the them, V9 said We use V14 (Restorative Aide). R179 said in English Get V14. I speak to her (pointing to surveyor). V14 entered the room and translated for R179. R179 was asked how he communicates with staff. Through V14, R179 stated He asks around to get someone to help him out and interpret. R179 stated through V14 that he asks V14 or a housekeeper to help him, or he asks another resident who speaks Spanish. When V14 interpreted the question Does anyone use an app or their phone or computer to interpret and speak to you? R179 stated no. When asked if anyone uses a communication board where he can point to what he wants to communicate, R179 stated no. Surveyor did not observe a communication board in R179's room. On 5/22/2024 at 3:45 PM, R179's care plan dated 4/26/2025 and created by V7 (LPN) was reviewed. Focus: Communication: Resident is at risk for complications with communication related to Goal: Staff will anticipate and meet all of residents needs on a daily basis throughout next review. Interventions: Encourage use of communication cards/board. Policy entitled Comprehensive Care Plan dated 1/2023 stated in part: The facility must develop a comprehensive person-centered care plan for each resident. Policy. 3. The care plan will include a focus, measurable goal and interventions specific to the resident's medical, nursing, mental and psychosocial needs. On 5/23/2024 V1 (Administrator) was asked for the facilities resident rights policy. The Illinois Long-Term Care Ombudsman Program Residents' Rights for People in Long Term Care Facilities was provided. It states in part: You have the right to complete information about your medical condition and treatment in a language that you understand. Policy titled Communications dated 1/2023 stated in part: (continued on next page)

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	145661	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ryze West	5130 West Jackson Boulevard Chicago, IL 60644

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy: (Facility) will take reasonable steps to ensure that persons with limited English proficiency (LEP) have meaningful access and an equal opportunity to participate in our services, activities, programs and other benefits. The policy of (facility) is to ensure meaningful communication with LEP patients/clients and their authorized representatives involving their medical condition and treatment.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 50057 Based on observations, interview and record review, facility failed to identify and address an alteration in skin integrity for one resident (R147) out of 35 residents in the sample. This failure resulted in unaddressed skin lesions and resident discomfort. Findings: On 05/21/24 at 12:40 PM R147 was observed to have multiple round lesions on the left arm. Some lesions were open and red. Some lesions were scabbed over. R147 showed surveyor his upper back and legs which had multiple lesions that are scabbed over. R147 stated that the lesions were uncomfortable. On 05/22/24 at 12:05 PM V17 (Wound Nurse) was interviewed and stated that wound care was no longer following R147. V17 stated that R147 had MRSA (Methicillin-resistant Staphylococcus aureus) and an infection on his cheek, but that heeled. V27 stated that nursing was previously putting an ointment on R147's arms. We are not aware of any wounds that he currently has. On 5/22/2024 at 12:10 PM, Surveyor and V17 (Wound Nurse) visited R147. R147 showed arms, upper back and legs with lesions present. Several of the lesions on R147's arm were bleeding. V17 stated I didn't know. I will follow up immediately. On 5/22/2024 at 3 PM, interviewed V13(LPN) who stated that she has texted with V35 (Nurse Practitioner) about R147 and Bacitracin was ordered BID (twice daily) and wound care was to follow up. On 5/23/2024 at 9:20 AM, R147 stated that he had not yet had cream put on his arms. On 5/23/2024 at 9;22 AM, V13 (LPN) was asked if the cream for R147 had arrived. V13 stated that Bacitracin was ordered yesterday, and she was waiting to hear from pharmacy. V13 stated I am not sure how medication is run here. On 5/23/2024 at 10 AM, V34 (Infection Prevention Nurse) was asked about the Bacitracin order for R147. V34 stated that from the time of order to initiation of a drug, it should be same day if the order is early enough. V34 accessed the electronic health record and stated that Bacitracin ointment was ordered on 5/22/2024 at 1330. That should have arrived yesterday. V34 stated I was not made aware that R147 was having issues. On 5/23/2024 at 11:27, V34 (Infection Prevention Nurse) stated that V34 and V17 (Wound Nurse) evaluated R147 and spoke with V44 (Wound Doctor). A treatment order was being initiated. R147 will require a dressing to the left arm and upper back. R147 had been placed on EBP. Pharmacy had been contacted and Bacitracin ointment was to arrive for R147 around 3 or 4 PM on 5/23/2025. On 5/23/2024 at 1:47 PM, R147's room was observed to have a sign for EBP (enhanced barrier precautions) on the door and a PPE (Personal protective equipment) cart outside of the room. Policy titled Skin Care Prevention dated 1/2023 and reviewed 1/2024 stated in part: Responsible Party: All Nursing Staff (continued on next page)

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Ryze West	5130 West Jackson Boulevard Chicago, IL 60644

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Guideline: 3. All residents will be evaluated for changes in their skin condition.

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F 0686 Level of Harm - Minimal harm or potential for 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** 47304 Based on observation, interview, and record review, the facility failed to follow care plan to ensure pressure redistribution mattress or low air loss mattress was provided as ordered and complete an assessment or tool used to identify resident at risk for pressure ulcer in a timely manner. These failures affected 1 (R90) resident reviewed for pressure ulcer in a sample of 35. The findings include: R90's health record documented admitted on 1/11/2024 with diagnoses not limited to Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, Type 2 diabetes mellitus without complications, Unspecified severe protein-calorie malnutrition, Nontraumatic intracerebral hemorrhage, Neuromuscular dysfunction of bladder, Hyperlipidemia, Gastro-esophageal reflux disease without esophagitis, Chronic atrial fibrillation, Iron deficiency anemia, Acquired absence of other specified parts of digestive tract, Dysphagia oropharyngeal phase, Essential (primary) hypertension, Gastrostomy status, Encounter for attention to colostomy, Gout, Malignant neoplasm of rectum, Primary generalized (osteo)arthritis, Peripheral vascular disease. On 5/21/24 at 10:19 AM R90 observed lying in bed, alert and oriented, verbally responsive, bed on lowest position with floor pads. With g-tube, no feeding infusing. No air mattress in place. Observed bilateral heel lift boots at bedside. With indwelling urinary catheter. On 5/22/24 At 9:22am V17 (Wound nurse) said she started working in the facility in June 2023. Skin check / assessment done upon admission. Skin preventive measures include cushion for wheelchair, air mattress or pressure reducing mattress, heel boots. Braden assessment is done upon admission, weekly x 4 weeks from admission, quarterly thereafter and as needed. Score of 15 and under in Braden scale are considered at risk for skin breakdown / pressure ulcer, should put skin preventive measures to prevent skin alteration. V17 said if there is an order for air mattress, it should be in place because it is an order. Reviewed R90's EHR (Electronic Health Record) with V17 and said Stage IV pressure ulcer on coccyx was healed on 5/8/24. She said R90 is incontinent of bowel and is at risk for skin breakdown. Stated R90 has active order for air mattress. At 10:52 AM V2 (Director of Nursing / DON) said all physician order should be followed because it is an order, it is there for a reason and resident should have it. If there is an order for air loss mattress then it should be provided. R90's order summary report dated 5/21/24 showed an active order not limited to Low air loss mattress while in bed. Braden scale assessment dated [DATE] showed a score of 9.0 (Very High Risk). Care plan dated 1/15/24 documented in part: R90 has potential/at risk for alteration in skin integrity due to risk factors associated with incontinence, immobility, diabetes, anemia. Care plan interventions included but not limited to: Pressure redistribution mattress. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Minimum Data Set (MDS) dated [DATE] showed R90's cognition was severely impaired. She needed total assistance / dependent to staff with oral, toileting and personal hygiene, shower/bathe self, upper and lower body dressing, chair/bed, and toilet transfer. MDS showed R90 had Stage IV pressure ulcer that was noted at the time of admission/ reentry. Facility's policy for skin care prevention dated 1/2024 documented in part: - All residents will receive appropriate care to decrease the risk of skin breakdown. - For residents who are bed or chair bound, a chair cushion and pressure reducing mattress.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47304 Based on observation, interview, and record review, the facility failed to (a) ensure that smoking materials including cigarette and lighter were given to designated staff; (b) complete smoking assessment / evaluation in a timely manner; (c) develop comprehensive care plan and follow plan of care for smoking. These failures could potentially affect 4 (R28, R84, R92, and R132) residents reviewed for smoking in a total sample of 35. The findings include: R92's health record documented admitted on 2/16/2019 with diagnoses not limited to Alcohol dependence with withdrawal, Esophagitis, Thrombocytopenia, Gastro-esophageal reflux disease with esophagitis, Constipation, Personal history of covid-19, Age-related nuclear cataract bilateral, Tension-type headache, Vitamin d deficiency, Insomnia due to medical condition, Decreased white blood cell count, Spinal stenosis cervical region, Nontraumatic intracerebral hemorrhage, Cervicalgia, Dysphagia following other cerebrovascular disease, Traumatic hemorrhage of cerebrum, Unspecified cirrhosis of liver, Nicotine dependence, Encounter for attention to gastrostomy, Essential (primary) hypertension, Bipolar disorder, Post-traumatic hydrocephalus, Iron deficiency anemia, Presence of cerebrospinal fluid drainage device, Chronic viral hepatitis c. R132's health record documented admitted on 2/20/2024 with diagnoses not limited to Malignant neoplasm of supraglottis, Moderate protein-calorie malnutrition, Cerebral infarction, Chronic respiratory failure, Unspecified protein-calorie malnutrition, Unspecified asthma, Tracheostomy status, Periorbital cellulitis, Hypothyroidism, Auditory hallucinations, Major depressive disorder, Somnolence, Hypoxemia, Covid-19, Lymphedema, Opioid dependence, Essential (primary) hypertension, Anemia, Schizoaffective disorder, Nicotine dependence cigarettes, Thrombocytosis, Dysphonia, Opioid abuse with withdrawal, Dysphagia, Anogenital herpesviral infection. On 5/21/24 at 10:28am R132 observed sitting at the side of the bed, alert, and oriented x 3, verbally responsive, with tracheostomy tube at room air. With suction machine and oxygen at bedside. Stated she is using oxygen as needed. Observed a lighter on her bed, stated she is smoking and is keeping the lighter but not the cigarette. At 10:45am R92 observed lying in bed, alert and oriented x 3, verbally responsive, stated he is a smoker and showed a pack of cigarette from his packet. He said he is keeping his own cigarette but not the lighter. Stated he is ambulatory with walker. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/22/24 at 9:02am V16 (Social Service Director / SSD) said he started working in the facility in October 2023. Stated smoking assessment / evaluation is done within 48-72 hours upon admission then quarterly, significant change in condition or if there is any behavior related to smoking. He said smoking assessment is to gauge whether resident is safe to smoke independently or needs supervision and if resident is a safe smoker or not a safe smoker. V16 said if smoking assessment is not done as scheduled will not be able to know if resident is safe or not safe to smoke. He said staff observed residents during smoking schedule in the patio if they are safe to smoke or not and smoking care plan is done upon assessment and reviewed quarterly or as needed. Plan of care for smoking will include how much they smoke if resident is smoking safely in the facility and interventions appropriate for the resident. Care plan is a guide for staff to know how to care for resident or it is their plan of care that needed to be followed and reviewed. He said all residents should not have any smoking materials such as cigarette or lighter with them inside the facility whether they are safe smoker or not. If residents carry any smoking materials, they could give to another resident who is not a safe smoker and could start a fire in the facility. Reviewed electronic health record (EHR) of the following residents with V16: - R132 is a smoker. No smoking assessment and care plan found in EHR (Electronic Health Record). - R92's last smoking assessment was completed on 9/11/23. Minimum Data Set (MDS) dated [DATE] showed R92's cognition was moderately impaired. He needed set up/clean up assistance with eating, oral hygiene; Supervision / touching assistance with toileting and personal hygiene, shower / bathe self and upper and lower body dressing, chair / bed and toilet transfer. R92's care plan dated 9/11/2023 documented in part: Smoking preference: Resident makes the choice to continue to smoke and is at risk for SOB. Cigarette lighters are to be kept with cigarettes. Last smoking risk assessment found was dated 9/11/23 in R92's Electronic Health Record (EHR). MDS dated [DATE] showed R132's cognition was intact. She needed supervision / touching assistance with oral, toileting and personal hygiene, shower/bathe self, upper and lower body dressing, chair/bed and toilet transfer. MDS indicated tobacco use. Last smoking risk assessment found in R132's EHR was dated 12/9/22. No smoking care plan found in R132's EHR. Facility's smoking policy dated 1/2024 documented in part: - All residents who desire to smoke will be assessed by the interdisciplinary team to determine if the individual is appropriate for independent smoking. - Possessing, carrying, or holding materials used to smoke (including, but not limited to, cigarettes, cigars, loose tobacco, pipes, lighters, and matches) by residents is prohibited inside the building. Residents must give smoking materials to designated staff when they enter the building, even if the resident has been assessed to be independent in carrying such materials when off the premises. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	44103 On 5/21/24 at 12:28 PM, R28 was up in wheelchair in R28's room alert and able to verbalize needs. When asked if R28 smokes, R28 stated R28 smokes outside on the patio with staff supervision. On 5/22/24 at 1:41 PM, R28 was observed outside the patio smoking. R28 stated R28 keeps cigarettes with R28 but not the lighter. On 5/22/24 at 9:25 AM, Surveyor and V16 (Social Service Director) checked R28's electronic health records. V16 confirmed that the last smoking assessment completed for R28 was in 8/16/23 and smoking was not addressed in R28's care plan. 46342 Findings include: On 05/22/24 at 01:18 PM, during Resident Council Meeting interview R84 stated yes, I smoke, and I keep my stuff on me. Observed R84 remove from R84's pocket an orange color lighter and carton of cigarettes. R84's diagnosis included but not limited to Nicotine Dependence Cigarettes, Dementia, Cerebral Infarction, Hyperlipidemia, Atherosclerotic Heart Disease, Chronic Kidney Disease Stage 2, Heart Failure, Prediabetes, Peripheral Vascular Disease, Venous Insufficiency (Chronic) Peripheral, Hypertension, Alcohol Use. R84's MDS (Minimum Data Set) dated 02/28/24 indicates moderately impaired cognition with BIMS (Brief Interview for Mental Status) 10 out of 15 and tobacco use based on section J - Health Conditions. R84's most recent Smoking Risk Assessment Scored dated 01/28/24 documents in part scored 0-9 - Safe Smoker and monitor per facility safe smoking guidelines. R84's Smoking Behavioral Contract dated 01/28/24 documents in part resident responsibilities include adhere to the facility rules, policies, and guidelines (procedures). R84's smoking care plan dated 10/12/22 documents in part unsafe smoking issues related to behavior and interventions include but not limited to keep resident smoking materials in the medication room or activity closet.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 46342 Based on observation, interview and record review the facility failed to provide physician ordered oral nutritional supplements and other nutrition interventions. These failures potentially affected 2 residents (R18, R21) of 7 residents reviewed for nutrition in a total sample of 35. Findings include: On 05/21/24, during initial kitchen tour conducted between 8:57-9:55 AM V11 (Dietary Director) stated Magic Cup (fortified high calorie ice cream) supplements are in stock and are put on resident meal trays when listed on the meal ticket. Observed 8-ounce cartons of whole milk in the refrigerator and case of Magic Cup supplement stored in the facility freezer. On 05/21/24 at 12:20 PM, observed R18 eating lunch in the unit dining room. R18 received ground barbeque chicken, macaroni & cheese, spinach, frosted chocolate cake, and fruit punch on R18's lunch tray. R18's meal ticket read double portions, and Magic Cup with lunch. R18 did not to receive double portions and R18 did not receive a Magic Cup supplement or an equivalent substitution on R18's lunch tray. V7 (4th Floor Unit Manager/Licensed Practical Nurse) view R18's lunch plate and another resident's lunch tray and stated R18's portion looked like the same portion that everyone else got. At 12:33 PM, R18 consumed 100% of entire tray. There was no empty container of Magic Cup or other nutritionally equivalent supplement on R18's finished tray. On 05/22/24 at 12:48 PM, observed R21 eating lunch in the unit dining room. R21 received a hot dog on bun cut into smaller pieces, sweet potatoes, mixed vegetables, cake with frosting, and fruit punch. R21's meal ticket read Magic Cup with lunch. R21 did not receive a Magic Cup or ice cream or other nutritionally equivalent supplement. R21 meal ticket did not list whole milk to be served at lunch. R21 did not receive whole milk. On 05/22/24 at 2:43 PM, R21 said, I love whole milk, not that diet milk. R21 stated R21 only drinks whole milk at breakfast but R21 would love to get it spread throughout the day and would like to get it at lunch and dinner. R21 said, it would be good to help me gain weight. On 05/23/24 at 9:52 AM, V46 (Diet Technician) reviewed R21's meal ticket and stated based on the meal ticket R21 should be receiving super cereal (fortified hot cereal) at breakfast, whole milk at breakfast and dinner, and a Magic Cup w/lunch and dinner. V46 stated typically, milk is only served with breakfast and dinner unless ordered or requested by the resident. V46 stated whole milk can be used when it is the resident's preference or as a dietary intervention for weight gain. V46 stated Magic Cup is a fortified ice cream supplement and is also use as a dietary intervention for weight gain or for residents with poor appetite. V46 stated it is the kitchen's responsibility to put these items on the tray during tray line service and there is no storage area on the units so these items can only be provided by the kitchen. V46 stated the potential problem if a resident is not receiving a supplement or dietary intervention it could interfere with what the dietary intervention is trying to resolve for example weight loss, weight gain, wound healing. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/23/24 at 10:04 AM, V46 reviewed R18's meal ticket R18 and stated R18 should be receiving double portions with all R18's meals and a Magic Cup at lunch and dinner. V46 stated V46 does not know why these interventions are ordered for R18 but they are listed on the meal ticket so they should be provided to R18. On 05/23/24 at 11:30 AM, during phone interview V45 (Registered Dietitian) stated supplements like Magic Cups are put on the resident meal trays and are used to have residents gain weight, or to give residents extra calories and protein if they are assessed that they need more. V45 stated use of double portions as an intervention to add additional calories to a resident's meal plan can also be used. On 05/23/24 at 11:37 AM, V45 stated per R18's electronic health care record (EHR) R18's diet order is ordered as a mechanical soft, no added salt thin liquids with double portions with all meals and supplements include Magic Cup with lunch and dinner. V45 stated R18's weight was going down at one point, and R18's weights fluctuate but has been stable for one year. V45 stated R18 is on supplements due to history of weight loss. R18's Body Mass Index (BMI) is 23.6. which is within range for BMI for geriatrics (23-30). V45 stated V45 recommends continuing with these nutrition interventions because they are helping to support R18's weight maintenance. V45 stated R18 should have received the Magic Cup if in stock and double portions as ordered. V45 stated double portions means that all the items on the main plate (protein, starch, vegetable) are doubled. On 05/23/24 at 11:47 AM, V45 stated per R21's EHR R21's diet order is mechanical soft, with thin liquids and supplements include Magic Cup with lunch and dinner, Super cereal w/breakfast, and whole milk w/meals. V45 stated R21's BMI is 15.1 which is below desired BMI range for geriatrics (23-30). V45 stated R21's current weight is 77 pounds and this time last year R18 weighed 90 pounds (5/2023). V45 stated R21 has gained weight since (2/2024). V45 stated the goal is for R18 to continue to gain weight and the supplements are in place to promote this weight gain. V45 stated the Magic Cup with lunch should have been provided and the whole milk should be printed on R21's lunch ticket so the staff knows to put it on R21's tray. V45 stated the whole milk could be part of R21's plan for weight gain. V45 stated the potential problem if R21 is not getting the supplements or whole milk is that R21 would maintain R21's weight instead of gaining weight, and place R21 at risk for weight loss if R21's appetite/intake changes because then R21 would potentially not be getting the right nutrition. R18's diagnosis includes but not limited to Alzheimer's Disease, Age-Related Nuclear Cataract Right Eye, Combined Forms of Age-Related Cataract Left Eye, Heart Failure, Unspecified Dementia, Unspecified Osteoarthritis, Hypertension, Hyperlipidemia. R18's Order Summary Report dated 05/21/24 documents in part double portions with all meals and Magic Cup with lunch meal and Magic Cup with dinner meal. R18's MDS (Minimum Data Set) from 04/01/24 BIMS (Brief Interview for Mental Status) was 10 out of 15 indicating moderately impaired cognitive function. R18's nutrition care plan documents in part, R18 at risk for malnutrition and receives double portions all meals and hi (high) calorie frozen dessert afternoon and appropriate to prevent weight loss, malnutrition and per chewing difficulty. (continued on next page)

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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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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R18's printed meal ticket documents in part, Magic Cup at lunch and dinner, double portions at breakfast, lunch and dinner. R21's diagnosis includes but not limited to Spondylosis without Myelopathy or Radiculopathy, Cervical Region, Unspecified Severe Protein Calorie Malnutrition, Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Unspecified Cirrhosis Of Liver, Dysphasia, Primary Osteoarthritis Right Wrist, Chronic Viral Hepatitis C, Anemia, Hypomagnesemia, Hypokalemia, Unspecified Dementia, Anxiety Disorder, Encephalopathy, Hypertension, Age-Related Cognitive Decline, Abnormal Weight Loss, Limited Of Activities due to Disability, Reduced Mobility Personal History of Urinary Tract Infections, History of Falling. R21's Order Summary Report dated 05/24/24 documents in part whole milk with all meals, Magic Cup or ice cream with lunch meal, and Magic Cup or ice cream with dinner meal. R21's MDS (Minimum Data Set) from 04/01/23 indicates BIMS (Brief Interview for Mental Status) was 15 out of 15 indicating intact cognition. R21's nutrition care plan dated 02/2024 documents in part, resident had experienced unplanned weight loss and offer whole milk with meals frozen dessert BID (twice per day). R21's printed meal ticket documents in part, Magic Cup with lunch and dinner, whole milk with breakfast and dinner. Whole milk is not listed on lunch meal ticket. Facility provided kitchen policy titled, Supplements undated which documents in part: 1.) Supplements will be passed out as ordered in EMR (Electronic Medical Record) and per physician/RD (Registered Dietitian) recommendations to provide additional calorie/protein. 2.) Supplements are ordered by physician or RD and may include dietary additives such as: fortified foods, might shakes, med pass, magic cup and Ensure/Boost/Glucerna. 3.) Supplements will be provided at mealtimes on trays or nursing staff will pass depending on the supplement ordered. 4.) If a particular supplement is not available, an alternative may be substituted out that is of equivalent or increased nutritional value. Facility provided kitchen policy titled Double and Large Portions dated 09/01/21 which documents in part, increased portions are available for residents requiring extra calories or requesting extra food and double portions are served as double serving of food on the plate. Salad, dessert and beverage are served as standard portions.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 46342 Based on observation, interview, and record review the facility failed to provide total volume of prescribed gastrostomy tube feeding as prescribed by physician. These failures could potentially affect 2 (R59, R67) of 2 residents reviewed for nutrition and tube feeding in a sample of 35. Findings include: On 05/22/24 at 09:02 AM, surveyor observed R59's tube feeding hung at bedside and infusing at 65 ml per hour via pump. The tube feeding formula hanging was a 1-Liter (L) bottle of Jevity 1.5 and on the bottle was a label. The label was dated 05/21/24 at 2:00 PM, rate 65 ml per hour. On 05/22/24 at 9:03 AM, surveyor observed R67's tube feeding hung at bedside and infusing at 75 ml per hour via pump. The tube feeding formula hanging was a 1L bottle of Jevity 1.5 and the bottle was labeled with the date 05/21/24 at 2:00 PM, rate 75 ml per hour. On 05/22/24 at 9:12 AM, V20 (Licensed Practical Nurse) stated R59 and R67's tube feedings are turned off from 10 AM to 2 PM daily. V20 stated these tube feeding bottles were hung yesterday at 2 PM and that when nurses hang the tube feeding they label the bottle with the date and time started. On 05/22/24 at 10:04 AM, heard R67's tube feeding pump beeping. V7 (4th Floor Unit Manager/Licensed Practical Nurse) stated R67's tube feeding pump is beeping because the bottle is empty. V7 looked at the label on R67's 1L bottle of Jevity 1.5 and stated this bottle was hung yesterday at 2 PM. V7 stated at 2 PM the nurse on duty will hand a new bottle and tubing. On 05/22/24 at 10:30 AM, V20 looked at the label on R59's 1L bottle of Jevity 1.5 and stated this bottle was hung yesterday at 2 PM. V20 stated the nurses need to label and date the time the tube feeding was started when a new bottle is hung. Observed unmeasurable amount of formula still left in the 1L bottle of Jevity 1.5. Observed on outside of pump to indicate 1032 ml infused. V20 estimated volume of formula left in the 1L bottle to be approximately 250 ml. V20 stated V20 was going to throw this left over formula in the bottle out and would hang a new bottle at 2 PM. On 05/22/23, V2 (Director of Nursing) stated the nurse should be following the tube feed order as prescribed by the physician in the resident's electronic health record and document the volume infused in the MAR. V2 stated if there is still tube feeding formula left in the bottle at the time the order says to turn off the tube feeding then V2 would expect the nurse on duty to call the doctor and get further orders on how to proceed. (continued on next page)

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Ryze West	5130 West Jackson Boulevard Chicago, IL 60644

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/23/24 at 11:09 AM, via phone interview V45 (Registered Dietitian) stated residents on tube feedings are at higher nutritional risk because they are getting all their nutrition needs through artificial feedings. V45 stated V45 calculates calorie, protein and fluid needs and then use these estimated needs as a ballpark to determine how much tube feeding formula the residents should have to meet those needs. V45 stated V45 expects a resident receiving tube feedings to receive the total volume of the tube feeding formula ordered so the resident is getting the right amount of tube feedings formula to meet their nutritional needs. V45 stated R59 is NPO (receives nothing by mouth) and is 100% dependent on tube feedings for nutrition and hydration needs. V45 stated R59's current tube feed order is Jevity 1.5 @ 65ml per hour times 20 hours to provide total volume 1300 ml per day on 2 PM, off at 10 AM. V45 stated if R59 has not reached the total volume of 1300 ml by 10 AM then V45 would expect for nursing to leave the tube feeding running until the total volume of 1300 ml is infused. V45 stated this is important because otherwise R59 won't be getting all the calories, and protein needed. V45 stated if nursing is using a 1 liter bottle of Jevity 1.5 hung at 2 PM run at 65 ml per hour continuously there is no way R59 could receive 1300 ml of formula by 10 AM the following day, unless the nurses gave 300 ml via bolus which they would need a physician order to do or if a 2nd 1 liter formula bottle was hung which would have been labeled and dated with that hang time and in which case there would be a lot of extra formula still left in the tube feeding container. V45 stated of there was still tube feeding formula left in R59's same 1 liter bottle hung the day before at 2 PM than it does not sound like R59 received the 1300 ml he (R59) was supposed to, R59 got less. V45 stated R59 is at high nutrition risk and R59's BMI is 16.9 which means R59 is underweight. V45 stated the goal is for R59 to gain weight and there is a potential for R59 not to gain weight if R59 is not getting the total volume of tube feeding as ordered. V45 stated R67 is on a mechanical soft, thin liquids but R67 is refusing meals more than eating them. V45 stated based on staffing documentation of meal intake in R67's EHR it looks like R67 is consuming approximately one meal per day if that. V45 stated R67 is receiving tube feedings because he has a low weight and a history of weight loss but R67's weight has stabilized. V45 stated R67's current BMI is 19.2 which is within desired range for age but given that R67 has a diagnosis of malnutrition V45 wants him to be at a BMI of 21. V45 stated V45 would keep R67's tube feeding the same to promote weight gain. V45 stated R67's tube feeding order is to receive Jevity 1.5 @ 75 ml/hr times 20 hours until total volume of 1500 ml per day is infused, tube feeding on 2PM, off 10AM. V45 stated R67 should have received the full 1500 ml of Jevity 1.5 to make sure R67 is getting the calories calculated for him because we want him to gain weight. V45 stated if V45 is only getting 1 liter of Jevity 1.5 per day then that might be enough calories to maintain R67's weight but not enough for R67 to gain weight. V45 stated, I want him to get 1500 milliliters. R59 has diagnosis which includes but not limited to: Cerebral Infarction Due To Unspecified Occlusion Or Stenosis Of Right Middle Cerebral Artery, Hemiplegia, Unspecified Affecting Left Dominant Side, Dysphasia Oropharyngeal Phase, Chronic Obstructive Pulmonary Disease, Weakness, Lack Of Coordination, Need Assistance With Personal Care, Underweight, Moderate Protein Calorie Malnutrition, Anxiety, Diverticulosis Of Large Intestine, Adult Failure To Thrive, Encounter For Attention To Gastrostomy, Malignant Neoplasm of Colon, Unspecified Dementia, Gastritis, Major Depressive Disorder. R59's Order Summary Report dated 05/22/24 documents in part NPO diet start date 06/23/23 and enteral feeding order Jevity 1.5 @ 65 milliliters per hour times 20 hours total of 1300 milliliters per day up @ 2PM, off at 10 AM start date 02/14/24. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R59's Medication Administration Record (MAR) dated 05/01/24-05/22/24 document in part, enteral feeding order Jevity 1.5 @ 65 milliliters per hour times 20 hours total of 1300 milliliters per day up @ 2PM, off at 10 AM. R59's MAR includes the following information: 1.) Entry dated 05/08/24 documents day shift ml 65 ml, evening shift ml 585 ml, night shift ml 520 ml. Total tube feed volume administered calculated to be 1170 ml. 2.) Entry dated 05/16/24 documents day shift ml 260 ml, evening shift ml 65 ml, night shift ml 520 ml. Total tube feeding volume administered calculated to be 845 ml. 3.) Entry dated 05/17/24 documents day shift ml 260 ml, evening shift ml 65 ml, night shift ml 560 ml. Total tube feeding volume administered calculated to be 885 ml. 4.) Entry dated 05/19/24 documents day shift ml 65 ml, evening shift ml 520 ml, night shift ml 560 ml. Total tube feeding volume administered calculated to be 1145 ml. 5.) Entry dated 05/20/24 documents day shift ml 260 ml, evening shift 65 ml, night shift ml 520 ml. Total tube feeding volume administered calculated to be 845 ml. R59's nutrition care plan documents in part, R59 requires tube feeding related to dysphagia, TF (tube feeding) Jevity 1.5 @ 65 ml per hour times 20 hours total of 1300 ml per day, and interventions include resident will receive tube feeding and water flushes per physician orders. R59's MDS (Minimum Data Set) dated 05/01/24 BIMS (Brief Interview for Mental Status) scores 6 out of 15 indicating severe cognitive impairment. R59's progress note entry titled Monthly Enteral Note documents in part R59 diet NPO, and RD recommendation to continue with Jevity 1.5 @ 65 ml/hr times 20 hours total of 1300 ml per day, no new interventions. R67 has diagnosis which includes but not limited to: Cerebral Infarction, Hemiplegia and Hemiparesis Following Non-Traumatic Intracerebral Hemorrhage Affecting Right Dominant Side, Unspecified Protein-Calorie Malnutrition, Dysphasia, Aphasia, Encounter For Attention To Gastrostomy, Major Depressive Disorder, Adult Failure To Thrive, Thyrotoxicosis (Hyperthyroidism), Major Depressive Disorder, Generalized Anxiety Disorder, Muscle Weakness, Anemia, Seizures, Unspecified Kidney Failure, Syncope And Collapse. R67's Order Summary Report dated 05/22/24 documents in part general diet mechanical soft texture, thin consistency start date 10/20/23 and enteral feeding order Jevity 1.5 @ 75 milliliters per hour times 20 hours total of 1500 milliliters per day up @ 2PM, off at 10 AM start date 02/14/24. R67's Medication Administration Record (MAR) dated 05/01/24-05/22/24 document in part, enteral feeding order Jevity 1.5 @ 75 milliliters per hour times 20 hours total of 1500 milliliters per day up @ 2PM, off at 10 AM. R59's MAR includes the following information: 1.) Entry dated 05/08/24 documents day shift ml 75 ml, evening shift ml 675 ml, night shift ml 600 ml. Total tube feed volume administered calculated to be 1350 ml. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.) Entry dated 05/16/24 documents day shift ml 300 ml, evening shift ml 70 ml, night shift ml 600 ml. Total tube feeding volume administered calculated to be 970 ml. 3.) Entry dated 05/17/24 documents day shift ml 300 ml, evening shift ml 75 ml, night shift ml 640 ml. Total tube feeding volume administered calculated to be 1015 ml. 4.) Entry dated 05/19/24 documents day shift ml 75 ml, evening shift ml 600 ml, night shift ml 560 ml. Total tube feeding volume administered calculated to be 1235 ml. 5.) Entry dated 05/20/24 documents day shift ml 300 ml, evening shift 75 ml, night shift ml 600 ml. Total tube feeding volume administered calculated to be 975 ml. R67's nutrition care plan documents in part, R67 requires tube feeding, regular pleasure feeding and TF - Jevity 1.5 @ 75 ml per hour times 20 hours total of 1500 ml per day, and interventions include administer tube feeding and water flushes per physician orders. R67's MDS (Minimum Data Set) dated 04/01/24 BIMS (Brief Interview for Mental Status) not conducted, documents in part, resident is rarely/never understood. R67's progress note entry titled Monthly Renal Note dated 03/05/24 documents in part R67 history of significant weight flux and RD recommendation to continue with Jevity 1.5 @ 75 ml/hr times 20 hours total of 1500 ml per day to provide a total of 2250 kcal (kilocalories), 96 grams of protein. R67's Intervention/Task for Amount Eaten dated from 05/01/24 to 05/22/24 document in part NA (Not Applicable) or refusing meal except for the following meal on 05/08/24, 05/10/24, 05/12/24, 05/15/24, 05/16/24, 05/17/24, 05/20/24, 05/21/24. Facility policy titled, Tube Feeding dated 1/2024 documents in part, nasogastric, gastrostomy and jejunostomy tubes are used when an alternate method of nutrition is needed, continuous tube feedings are based upon a 22 hour consumption period or other time frame based on individual resident need per Registered Dietician assessment and delivered over 24 hour period, tube feeding intake is documented on the MAR (Medication Administration Record), the tube feeding will be labeled with the date and time hung as well as the initials of the person hanging the feeding, document tube feeding delivered, and alert healthcare provider of any issues or concerns.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44103 Based on observations, interviews, and record reviews, the facility failed to follow residents' care plans to ensure physician orders were followed and administer the correct oxygen flow rate for 2 (R39, R148) out of 2 residents reviewed for respiratory care in the final sample of 35. Findings Include: 1) On 5/21/24 at 10:56 AM, R39 was lying in bed alert and able to verbalize needs. R39 was noted using oxygen (O2) via nasal cannula with the flow rate set to 1.5 liters per minute (LPM). When asked R39 if R39 changes the dial on R39's oxygen, R39 answered, The nurse sets that up. I don't touch it. R39 stated that R39 uses oxygen for R39's diagnoses of Asthma and Chronic Obstructive Pulmonary Disease (COPD). On 5/22/24 at 9:53 AM, R39 was resting in bed alert and awake. R39's was using oxygen via nasal cannula with the flow rate set to 1 LPM. R39 denied changing the flow rate. 2) On 5/21/24 at 11:00 AM, R148 resting in bed alert and able to verbalize needs. R148 stated R148 has been in the facility for almost two months. R148 was receiving oxygen via nasal cannula with the flow rate set to 1.5 LPM. R148 stated that the nurses set up how much oxygen R148 is supposed to get. R148 stated R148 has diagnosis of COPD. On 5/22/24 at 09:57 AM, interviewed V18 (Unit Manager/Licensed Practical Nurse) and stated that oxygen is administered to the residents based on the doctor's orders and the Nurses setup the flow rate. Surveyor and V18 checked R39 and R148's physician orders in their electronic health records. R39 has an order for 2-3 liters of oxygen every shift and R148 has an order for 2-4 liters continuous oxygen. On 5/22/24 AM at 10:20 AM, interviewed V2 (Director of Nursing) and stated that there should be a physician's order for how much oxygen the resident is supposed to receive. It's the nurses' responsibility to do rounds to make sure the resident is getting the correct order of the oxygen. If not, they must inform the doctor, educate the resident, and care plan it. V2 stated that the nurses monitor the residents' oxygen, and the Certified Nursing Assistants (CNAs) should be able to look at it and inform the nurse if there is something wrong. V2 stated that the physician's orders should be followed and if the resident can control their own oxygen setting, then there should be an assessment and an order for self-administration. V2 stated that if the resident does not get the correct oxygen setting per physician's order, the resident could potentially de-saturate. R39's electronic health records (EHR) show R9 has diagnoses not limited to Chronic Respiratory Failure with Hypoxia, Asthma, Obstructive Sleep Apnea, Pulmonary Hypertension, and Acute on Chronic Systolic Congestive Heart Failure (CHF). R39's Minimum Data Set (MDS) dated [DATE] shows R39 is cognitively intact. R39's physician orders show an order for: Oxygen (02) @ 2-3 Liters/Minute per nasal cannula, Maintain 02 Saturation @ 92% or greater ordered on 1/13/2023. R39's EHR does not have an order and no assessment for self-administration. R39's care plan with date initiated 1/13/23 documents R39 has oxygen therapy prescribed related to CHF, asthma, history of respiratory failure with one intervention that reads, Administer oxygen per physician orders: see orders. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R148's EHR shows R148 has diagnoses not limited to Unspecified Systolic (Congestive) Heart Failure, COPD, Asthma, and Dyspnea. R148's MDS date 4/12/24 shows R148 is cognitively intact. R148's physician orders show an order for: Continuous Oxygen @ 2-4L every shift ordered on 4/3/24. R148's EHR does not have an order and no assessment for self-administration. R148's care plan with date initiated 4/16/24 documents R148 has oxygen therapy prescribed for CHF, COPD, Asthma, and Pneumonia with one intervention that reads in part: Administer oxygen per physician orders. The facility's policy titled; OXYGEN THERAPY dated 1/2024 reads in part: 1. Residents who require oxygen therapy will have a physician order in their medical record which includes amount of O2 to be administered, route of administration, and indication of use

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45110 Based on interview and record review the facility [A] failed to ensure the physician documented in one [R125] resident's clinical record their assessment, current condition, and medical problems for each visit, [B] failed to ensure the physician sign and date psychotropic narcotic medication. These failures resulted in R125 not receiving a prescribed psychotropic medication for nine days. Findings Include: R125's clinical indicates in part, he is a twenty-eight-year-old admitted on [DATE], with the medical diagnosis of attention-deficit hyperactivity disorder, depression, paraplegia, neuromuscular dysfunction of bladder, essential (primary) hypertension. R125's physician order dated 5/15/24- Dextroamphetamine Sulfate Oral Tablet 5 MG (Adderall) [Controlled Drug], give 1 tablet by mouth in the morning and afternoon for ADHD. R125's Progress Notes: Documented in part. Dated 4/28/24- Nursing Note-R125 refused car and weights, he became verbally aggressive, nurse practitioner gave order for psych consult. R125's Progress Notes: Documented in part. 5/14/24- nurse note: R125 request to psychiatrist. 5/15/24- nurse note: [V2 Director of Nursing] Psychiatrist assessed R125 and prescribed new order Dextroamphetamine Sulfate Oral Tablet 5 MG (Adderall) [Controlled Drug], give 1 tablet by mouth in the morning and afternoon for ADHD. Carried out orders. Next visit with psychiatrist in one week. 5/15/24 thru 5/23/24- No documentation from V47 [Psychiatrist]. R125's Medication Administration Sheet: 5/15/24- Dextroamphetamine Sulfate Oral Tablet 5 MG (Adderall) [Controlled Drug], give 1 tablet by mouth in the morning and afternoon for ADHD. [Medication was not administered 5/15/24 thru 5/23/24. On 5/21/24 at 11:37 AM, R125 stated, I was admitted here on 4/27/24. I requested to see a psychiatrist, but I was not seen until 5/15/24. The psychiatrist [V47] on 5/15/23, reorders my medication, Dextroamphetamine Sulfate that I been taking since I was sixteen years old. On 5/16/24, I did not receive my mediation. I been asking different nurses, why I have not received the Dextroamphetamine Sulfate. Some nurses told me they will call pharmacy, other nurses said they was going to call V47. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	I don't think the nurses called V47. Not having my medication has made me feel terrible, feeling sad, depressed, tired, disorganized, and not wanting to move around to allow ADL care. I just been staying in my room, not wanting to be bothered. On 5/22/24 at 1:35 PM, (Face to Face Interview) V47 [Psychiatrist] stated, I assessed R125 for the first time on 5/15/24. R125 expressed he needed the medication Dextroamphetamine Sulfate Oral Tablet 5 MG, that he has taken since a teenager. After my assessment it was determined that R125 did in fact need the medication to treat attention-deficit hyperactivity disorder [ADHD]. I completed a form with V2 [Director of Nursing] and she was to fax the form to pharmacy. The sign form to pharmacy will allow any of my orders for narcotics to be filled and delivered, and my signature will remain of file with the pharmacy. I did not receive any notification from nursing staff that R125 did not receive his medication. I was not made aware the pharmacy did not receive the completed form. I did not give an order to place the medication on hold. Not receiving Dextroamphetamine Sulfate, could cause the resident to feel sad, a down mood, tired, and poor concentration. I will go up to R125's room and assess his mood and behavior. I will complete the required forms and submit them to pharmacy, R125 will have his medication today. I did complete R125's psychological assessment. I did not have time to document my encounter. I will complete our encounter today for 5/15/24. On 5/22/24 at 3:10 PM, V2 [Director of Nursing] stated, I placed in the order for R125's medication Dextroamphetamine Sulfate Oral Tablet 5 MG. I received the order from V47 on 5/15/24. V47 was supposed to complete a prescription and fax it to the pharmacy. I did place in the progress note in R125's clinical record. I thought V47 completed the prescription and faxed the order over to pharmacy. I was not made aware that R125 did not receive his medication from pharmacy. The procedure for any narcotic order, a prescription must be completed and faxed to pharmacy. If the medication was not delivered, the nursing staff should first call pharmacy to find out the reason why the resident's medication was not delivered. Then call the physician for any need prescriptions or forms. If a resident does not receive Dextroamphetamine Sulfate, the behaviors potentially can continue or worsen. V47 should document his assessments and encounter with the resident. On 5/23/24 at 12:35PM, R125 stated, I did not receive my Dextroamphetamine Sulfate Oral Tablet 5 MG, today. I did not see V47 yesterday. The first and last time I saw him was on 5/15/24. My nurse V8 [Licensed Practical Nurse] told me the prescription was faxed yesterday (5/22/24). On 5/23/24 at 12:57 PM V8 stated, V47 told me yesterday that he faxed R125's medication to the pharmacy. On 5/23/24 at 1:00 PM, V17[Wound Care Nurse] stated, I will call the pharmacy to find out if the prescription was faxed. V17 phoned the pharmacy on speaker in the presents of V8 and surveyor. The pharmacist said there was no prescription on file. V17 was transferred to the data entry department, it was verified there was no fax, e-script, sent to the pharmacy for R125. V8 stated, I will call V47 for a script. On 5/23/24 at 3:00 PM, R125's clinical record did indicate or note any documentation from V47 assessment encounter for 5/15/24. Policy documented in part: (continued on next page)

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 05/24/2024

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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Controlled Substance Orders (No Date) -A controlled substance medication will be dispensed by the pharmacy if all state and federal requirements are met. -A controlled substance prescription will only be accepted and dispensed if the pharmacy receives a valid prescription. -A valid controlled substance prescription can be received by the pharmacy by the following ways. Electronically, fax, or phone call. -Once the valid prescription is received from the physician the medication will be delivered in the next delivery. Facility Assessment Tool dated 11/2023 -Medical record- Tracking of physician visits -Mental Health- Manage the medical conditions and medication related issues causing psychiatric symptoms and behavior. -Identify and implement interventions to help support individuals with issues such as dealing with anxiety, depression, and other psychiatric diagnosis. -Medications, awareness of any limitations of administering medications to assess and management -Facility resources need to provide competent support and care for our resident population every day including medical physician services, and behavior and mental health providers

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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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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 47304 Based on interview and record review, the facility failed to ensure to have sufficient certified nursing assistant (CNA) on weekends to care for residents' needs based on the staffing scheduling, PBJ (Payroll Based Journal) staffing data report and facility assessment. This failure could potentially affect 180 residents residing in the facility as of census 5/21/24. The findings include: On 5/21/24 at 10:45 AM R92 observed lying in bed, alert, and oriented x 3, verbally responsive, with long beard more than 5inches. Stated he can have staff assist him with shaving. He said staff did not offer or assist him with shaving. At 11:19 AM Requested V3 (Restorative Nurse) to R92's room and R92 stated he wanted his beard shaved off. R92 said beard is about 5-6 inches long and he wanted to take off everything. On 5/22/24 at 10:15 AM V19 (Scheduler / Staffing Coordinator) said she has been working in the facility for about 6 months. V19 said, V19 schedules both nurses and CNAs. V19 said, facility does not use agency for both nurses and CNAs. V19 said, the breakdown for staff schedule to work daily is as follows: 2nd floor 7-3 and 3-11 shift should be 4 CNAs and 2 nurses each shift and for 11-7 shift should be 3 CNAS and 1-2 nurses. 3rd floor 7-3 and 3-11 shift should have 3 CNAs and 2 nurses each shift and for 11-7 shift should have 3 CNAs and 1 nurse. 4th floor 7-3 and 3-11 shift should have 4 CNAs and 2 nurses each shift and 11-7 shift 3 CNAS and 1 nurse. Total staff for 7-3 and 3-11 shift = 11 CNAS and 6 nurses each shift. Total staff for 11-7 shift = 9 CNAS and 3-4 nurses. V19 said, total CNAs per day shoud be 31 CNAs and total nurses per day should be 15-16 nurses. V19 said same number of staff (CNAs and nurses) for weekdays and weekends. She said weekends are challenging due to call off, most call off happens on a weekend. Stated we are trying to fill up the shift. Nursing managers are coming if they need to. For the most part, we are keeping the same total number of staff but at times we can't be due to short notice for call off. Surveyor reviewed Daily Schedule from 4/6/24 to 5/19/24 with V19 and the document showed facility did not meet staffing numbers for cna's on 13 days. At 10:52AM V2 (Director of Nursing / DON) stated average CNAs working everyday should be around 10-12 per shift, about 30 CNAs per day. CNA is working 7.5hours per shift. She said at times weekend is a challenge, can't control call off, staff is doing their best to care for residents. Managers are working on the floor if needed. On 5/23/24 at 12:35pm V1 said at least 30-32 CNAs and 3 restorative aides working everyday including weekends to work and care for residents. She said team is always working together and managers working on the floor to meet the needs of the residents. Surveyor reviewed Payroll Based Journal (PBJ) report and showed inadequate staffing from 1/6/24 to 3/10/24 on 15 days. (continued on next page)

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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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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	PBJ staffing data report FY (Fiscal Year) 1 2024 (October 1 - December 31) showed: TRIGGERED for Excessively low weekend staffing. FACILITY ASSESSMENT TOOL dated 11/2023 documented in part: Nurse aides including Restorative Aides: 35-39 per day. Direct care staff: CNAs Long Term Care Units 1:12ratio Days; 1:12 ratio Evenings ; 1:12 ratio Nights. Facility's census report dated 5/21/24 showed 180 residents. Facility staffing policy dated 1/2024 documented in part: To have appropriate numbers of staff available to meet the needs of the residents. Staffing is based on the IDPH formula for determining numbers and levels of staff.

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F 0742 Level of Harm - Actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45110 Based on observation, interviews, and record reviews the facility failed to provide the appropriate treatment to attain the highest practical mental and psychosocial wells-being of one [R125] resident reviewed in a sample of 35. This failure resulted in R125 feeling sad, depressed, tired, and refusing care. Findings include: R125's clinical indicates in part, he is a twenty-eight-year-old admitted on [DATE], with the medical diagnosis of attention-deficit hyperactivity disorder, depression, paraplegia, neuromuscular dysfunction of bladder, essential (primary) hypertension. R125's physician order dated 5/15/24- Dextroamphetamine Sulfate Oral Tablet 5 MG (Adderall) [Controlled Drug], give 1 tablet by mouth in the morning and afternoon for ADHD. R125's Progress Notes: Documented in part. Dated 4/28/24- Nursing Note-R125 refused care and weights, he became verbally aggressive, nurse practitioner gave order for psych consult. 4/28/24-Nurse note: refused ADL care and increase in anxiety. 4/29/24-Nurse note: refused ADL care. 5/2/24-nurse practitioner note requested to go back on ADHD meds, and psychiatry consult ordered. 5/2/24- social service note: R125 presents with moderate severe depression. 5/3/24-nurse note refused ADL care. 5/4/24- nurse note: refused ADL care, shower, and lab work. 5/5/24- nurse note: picking wounds. 5/6/24- nurse note: attempted to throw away personal belongings. 5/7/24 -nurse note: picking wounds. 5/12/24, 5/13/24 nurse note: refused ADL care. 5/14/24- nurse note: R125 request to psychiatrist. 5/15/24- nurse note: [V2 Director of Nursing] Psychiatrist assessed R125 and prescribed new order Dextroamphetamine Sulfate Oral Tablet 5 MG (Adderall) [Controlled Drug], give 1 tablet by mouth in the morning and afternoon for ADHD. Carried out orders. Next visit with psychiatrist in one week. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	5/15/24 thru 5/23/24- No note from psychiatrist [V47]. 5/20/24 nurse note: refused skin treatment. 5/22/24 nurse note: refused ADL care. 5/23/24 nurse note at 13:51 (1:51PM) phoned V47 regarding prescription for Dextroamphetamine Sulfate Oral Tablet 5 MG (Adderall). R125's Medication Administration Sheet: 5/15/24- Dextroamphetamine Sulfate Oral Tablet 5 MG (Adderall) [Controlled Drug], give 1 tablet by mouth in the morning and afternoon for ADHD. [Medication was not administered 5/15/24 thru 5/23/24. On 5/21/24 at 11:37 AM, R125 stated, I was admitted here on 4/27/24. I requested to see a psychiatrist, but I was not seen until 5/15/24. The psychiatrist [V47] on 5/15/23, reorders my medication, Dextroamphetamine Sulfate that I been taking since I was sixteen years old. On 5/16/24, I did not receive my mediation. I been asking different nurses, why I have not received the Dextroamphetamine Sulfate. Some nurses told me they will call pharmacy, other nurses said they was going to call V47. I don't think the nurses called V47. Not having my medication has made me feel terrible, feeling sad, depressed, tired, disorganized, and not wanting to move around to allow ADL care. I just been staying in my room, not wanting to be bothered. On 5/22/24 at 1:35 PM, (Face to Face Interview) V47 [Psychiatrist] stated, I assessed R125 for the first time on 5/15/24. R125 expressed he needed the medication Dextroamphetamine Sulfate Oral Tablet 5 MG, that he has taken since a teenager. After my assessment it was determined that R125 did in fact need the medication to treat attention-deficit hyperactivity disorder [ADHD]. I completed a form with V2 [Director of Nursing] and she was to fax the form to pharmacy. The sign form to pharmacy will allow any of my orders for narcotics to be filled and delivered, and my signature will remain of file with the pharmacy. I did not receive any notification from nursing staff that R125 did not receive his medication. I was not made aware the pharmacy did not receive the completed form. I did not give an order to place the medication on hold. Not receiving Dextroamphetamine Sulfate, could cause the resident to feel sad, a down mood, tired, and poor concentration. I will go up to R125's room and assess his mood and behavior. I will complete the required forms and submit them to pharmacy, R125 will have his medication today. I did complete R125's psychological assessment. I did not have time to document my encounter. I will complete our encounter today for 5/15/24. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	On 5/22/24 at 3:10 PM, V2 [Director of Nursing] stated, I placed in the order for R125's medication Dextroamphetamine Sulfate Oral Tablet 5 MG. I received the order from V47 on 5/15/24. V47 was supposed to complete a prescription and fax it to the pharmacy. I did place in the progress note in R125's clinical record. I thought V47 completed the prescription and faxed the order over to pharmacy. I was not made aware that R125 did not receive his medication from pharmacy. The procedure for any narcotic order, a prescription must be completed and faxed to pharmacy. If the medication was not delivered, the nursing staff should first call pharmacy to find out the reason why the resident's medication was not delivered. Then call the physician for any need prescriptions or forms. If a resident does not receive Dextroamphetamine Sulfate, the behaviors potentially can continue or worsen. V47 should document his assessments and encounter with the resident. On 5/23/24 at 12:35PM, R125 stated, I did not receive my Dextroamphetamine Sulfate Oral Tablet 5 MG, today. I did not see V47 yesterday. The first and last time I saw him was on 5/15/24. My nurse V8 [Licensed Practical Nurse] told me the prescription was faxed yesterday (5/22/24). On 5/23/24 at 12:57 PM V8 (Licence Practical Nurse) stated, V47 told me yesterday that he faxed R125's medication to the pharmacy. On 5/23/24 at 1:00 PM, V17[Wound Care Nurse] stated, I will call the pharmacy to find out if the prescription was faxed. V17 phoned the pharmacy on speaker in the presents of V8 and surveyor. The pharmacist said there was no prescription on file. V17 was transferred to the data entry department, it was verified there was no fax, e-script, sent to the pharmacy for R125. V8 stated, I will call V47 for a script. Policy documented in part: Controlled Substance Orders (No Date) -A controlled substance medication will be dispensed by the pharmacy if all state and federal requirements are met. -A controlled substance prescription will only be accepted and dispensed if the pharmacy receives a valid prescription. -A valid controlled substance prescription can be received by the pharmacy by the following ways. Electronically, fax, or phone call. -Once the valid prescription is received from the physician the medication will be delivered in the next delivery.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ryze West	5130 West Jackson Boulevard Chicago, IL 60644

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 39779 Based on observation, interview, and record review the facility failed to a.) ensure narcotic medications were administered in accordance with physician orders, b.) ensure the narcotic count was correct at the change of shift and c.) document ordered narcotic medications when given for 2 (R76, R118) of 2 residents reviewed in 2 of 3 medication carts. Findings Include: On 05/21/24 at 09:59 AM the third-floor medication cart 2 was reviewed with V5 (Licensed Practical Nurse). R76 Physicians order document in part: Morphine Sulfate Oral Solution 20 MG (Milligram)/5ML (Milliliter) 0. 25 ml sublingually every 8 hours for pain -Start Date- 04/17/24. During the narcotic reconciliation review R76 Individual Controlled Substance Record document: Date received 04/19/24. Quantity received 30 ML (Milliliter) with 43 doses given. First dose dispensed 04/19/24 at 06:00 AM. On the April and May Medication Administration Record dated between 04/19/24 06:00AM and 06:00 AM 05/21/24 there were only seventy-four doses administered out of ninety-seven scheduled doses with twenty-three doses refused. Amount observed on R76 Individual Controlled Substance Record document amount remaining 19.25 ML. Surveyor asked V5 the total that was remaining in the bottle and V5 responded 27 milliliters is in the bottle and is over the 19.25 ml on the narcotic sheet. I will tell the supervisor. The narcotic count is done at the change of shift. R76 receives 0.25 ml of the Morphine Sulfate, and I did not notice it was over this morning. When the count is off, we notify the supervisor. On 05/23/24 the facility provided R76 updated Controlled Substances Proof of Use form document in part: Morphine 20 mg/ml give 0.25 ml every 8 hours sublingual for pain. Amount received 27.0 ml, Date received 05/21/24, Quantity remaining 26.5 ml. On 05/12/24 at 10:28 AM the fourth-floor medication cart 1 was reviewed with V6 (Licensed Practical Nurse). R118 Physician order document in part: Morphine Sulfate (Concentrate) Solution 20 MG/ML Give 5 mg sublingually every 3 hours as needed for Severe Pain Give 5-10 mg or 0.25ml-0.5ml q (every) 3hr (hours). R118 Controlled Substances Proof of Use document: Amount received 30 ML. R118 received Morphine a total of 36 times with a documented quantity remaining of 17.5 ML with only 15 ML observed remaining in bottle. Surveyor asked V6 to verify the amount of Morphine Sulfate remaining in the bottles, V6 responded 15 ML. I did not notice it this morning, I might have been moving too fast. On 05/23/24 the facility provided R118 updated Controlled Substances Proof of Use form document in part: Morphine Sulfate 20 mg/ml give 5-10 mg or (0.25 ml-0.5 ml) every 3 hours prn (as needed) for pain. Amount received 15.0 ml, Quantity remaining 14.0 ml. (continued on next page)

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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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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/22/24 at 10:42 AM V2 (Director of Nursing) stated Narcotics are counted at the change of shift. One nurse checks the medications and one nurse check the narcotic book. They count the medications together and if there is something wrong the nurse let someone know immediately. I heard about the narcotic count was off with the liquids for R76 and R118. We started the education on proper exchange of narcotic keys and to ensure the narcotic count, it is accountability. The nurses are to count with someone not just take the key and go. The count was corrected on the narcotic sheets. When medications are administered the nurse should make sure the medication count is correct. I expect the nurse to count the narcotics and not leave the key and walk off unit. On 05/23/24 at 11:31 AM V2 (Director of Nursing) stated when a resident is discharged from the facility the medications are sent with them. None of the resident medications should remain in the medication cart. In-Service, Education and Staff Development undated document in part: Topic: Medication labeling and storage. Medications and biologicals are stored safely, securely, and properly following the manufacturer or supplier recommendations. In-service sign in sheet attached. In-Service, Education and Staff Development undated document in part: Topic: Controlled substances. In-service sign in sheet attached. Policy: Titled Controlled Substance reviewed 01/10/24 document in part: Medications classified by the FDA as controlled substances have high abuse potential and may be subject to special handling, storage, and record keeping. 7. While a controlled substance is in use the nursing staff will maintain the following medication records. 8. Record each dose at the time of administration on the following: 9. MAR a. Date b. Time c. Initial of nurse administering dose. 10. Controlled Substances Count Sheet a. Date b. Time c. Signature (which includes minimum of first initials) of nurse who administered dose d. Number of doses remaining. 11. All schedule II-controlled substances (and other schedules if facility policy so dictates) will be counted each shift or whenever there is an exchange of keys between off-going and on-coming licensed nurses. The two nurses will: a. Inspect both the drug package and the corresponding count sheet to verify the accuracy of the amount remaining. d. Both nurses will sign the Shift/Shift Controlled Substance Count Sheet acknowledging that the actual count of controlled substances and count sheet matches the quantity documented. Discrepancies: a. Any discrepancy in the count of controlled substances shall be reported in writing to the responsible supervisor. b. The supervisor shall institute an investigation to determine the reason for the discrepancy. The record shall then be updated.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47304 Based on interview and record review the facility failed to follow their policy to (a) obtain an informed consent for psychotropic medication use; (b) ensure PRN (as needed) psychotropic medication will have a duration of no longer than 14days; (c) attempt Gradual Dose Reduction (GDR) for psychotropic medication use; (d) complete AIMS (Abnormal Involuntary Movement Scale) test in a timely manner. These failures could potentially affect 3 (R3, R130, R132) residents reviewed for Unnecessary Psychotic medication use in a sample of 35. The findings include: R132's health record documented admitted on 2/20/2024with diagnoses not limited to Malignant neoplasm of supraglottis, Moderate protein-calorie malnutrition, Cerebral infarction, Chronic respiratory failure, Unspecified protein-calorie malnutrition, Unspecified asthma, Tracheostomy status, Periorbital cellulitis, Hypothyroidism, Auditory hallucinations, Major depressive disorder, Somnolence, Hypoxemia, Covid-19, Lymphedema, Opioid dependence, Essential (primary) hypertension, Anemia, Schizoaffective disorder, Nicotine dependence cigarettes, Thrombocytosis, Dysphonia, Opioid abuse with withdrawal, Dysphagia, Anogenital herpesviral infection. On 5/22/24 at11:24 AM R132's order summary report dated 5/21/24 with active order not limited to: FLUoxetine HCl Oral Tablet 20 MG Give 1 capsule by mouth in the morning for MDD (Major Depressive Disorder). QUEtiapine Fumarate Oral Tablet 25 MG Give 12.5 mg by mouth two times a day for schizoaffective disorder. No AIMS (Abnormal Involuntary Movement Scale) assessment and no GDR evaluation or documentation found in R132's EHR (Electronic Health Record). Consultant pharmacist's medication regimen review dated 5/23/24 documented in part: Antipsychotics have the capacity to cause tardive dyskinesia and other movement disorders. AIMS TEST APPEARS TO BE DUE. Recommend movement test, such as AIMS, be performed initially (within 30 days), and then at least every 6 months while R132 continues on antipsychotic therapy. Care plan dated 3/4/24 documented in part: R132 has the psychotropic medication. Care plan included interventions not limited to MD to consider dosage reduction when clinically appropriate. Monitor/record/report to MD side effects and adverse reactions of psychoactive medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking). MDS dated [DATE] showed R132's cognition was intact. She needed supervision / touching assistance with oral, toileting and personal hygiene, shower/bathe self, upper and lower body dressing, chair/bed and toilet transfer. MDS indicated antipsychotic medication use. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/23/23 around 2:20 PM V2 (Director of Nursing / DON) said no GDR documentation for psychotropic medication use found in R132's health record. V2 provided AIMS assessment with signed date on 5/23/24. Facility's policy for psychotropic medication program dated 1/2024 documented in part: The purpose is to promote the safe and effective use of psychotropic medications. To ensure the lowest dose of medication is used, for the shortest time frame. To guarantee a resident's quality of life is enhanced by the medication usage. The resident and or resident representative are aware of the potential side effects and the facility obtains an informed consent for the use of the psychotropic medication. Once a resident is placed on a psychotropic medication the facility monitors the resident for side effects and adverse reactions, addresses the use of the medications in the comprehensive plan of care, and assess the resident for a GDR. PRN psychotropic medications will have a duration of no longer than 14 days unless there are documented behaviors and rationale provided and documented by the Psychiatrist /APN/Primary physician. PRN Antipsychotic medications MAY NOT be extended for a duration of longer than 14 days. These medications must be re-evaluated every 14 days if it is determined the resident requires them on a PRN basis. A baseline AIMS test will be done by the psychotropic nurse or designee prior to starting any new antipsychotic medication and at least every 6 months thereafter. 46342 R3's electronic health record (EHR) documented admitted [DATE] with diagnosis includes but not limited to Unspecified Dementia, Anxiety Disorder, Major Depressive Disorder, Bipolar Disorder, and Restlessness and Agitation. R3's Order Summary Report dated 05/23/24 documents in part, Mirtazapine 15 mg give 1 tablet by mouth every evening shift related to Major Depressive Disorder with start date of 07/10/21 and Olanzapine 5 mg by mouth at bedtime for bipolar disorder with restart date 05/19/24. R3's Consent for Psychotropic Medication provided by V2 (Director of Nursing) for Mirtazapine Tablet 15 mg by mouth every evening shift and Olanzapine Tablet 5 mg by mouth every evening shift dated 10/31/22. Review of R3's EHR on 05/22/24 did not find any recent Consent for Psychotropic Medication forms. On 05/22/24, reviewed in R3's EHR Consultant Pharmacist's Medication Record Regimen Review dated 05/06/24, 04/02/24, 03/05/24, 02/02/24 with no recommendations. (continued on next page)

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 05/24/2024
NAME OF PROVIDER OR SUPPLIER Ryze West		STREET ADDRESS, CITY, STATE, ZIP CODE 5130 West Jackson Boulevard Chicago, IL 60644	

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/23/24, V2 provided copy of R3's Consultant Pharmacist's Medication Record Regimen Review dated 05/23/24 which documents in part, antipsychotics have the capacity to cause tardive dyskinesia and other movement disorders. AIMS TEST APPEARS TO BE DUE. Recommend movement test, such as AIMS or DISCUS, be performed initially (within 30 days), and then at least every six months while this resident continues on antipsychotic therapy. On 05/23/24, V2 provided copy of R3's Psych: AIMS Assessment completed 05/23/24. R3's care plan initiated 05/17/21 documents in part, R3 has psychotropic medication prescribed for bipolar with goal that resident will be/remain free of drug related complications, including movement disorder, gait disturbance, or cognitive/behavioral impairment and consult with pharmacy, MD to consider dosage reduction when clinically appropriate. R130's EHR documented admitted [DATE] with diagnosis includes but not limited to Major Depressive Disorder Recurrent, Unspecified Dementia, Anxiety Disorder, Violent Behavior, Suicidal Ideations, Fibromyalgia, Chronic Obstructive Pulmonary Disease. R130's Order Summary Report dated 05/23/24 documents in part, Donepezil 5 mg HS for dementia start date 12/20/23, Haloperidol Lactate Injection 2 mg intramuscular every 6 hours as needed for aggression/agitation start date 12/19/23, Haloperidol Lactate Injection 2 mg by mouth every six hours as needed start date 12/19/23, Lorazepam 1 mg by mouth every 6 hours as needed for aggression/agitation start date 12/19/23, Lorazepam inject 1 mg intramuscularly every 6 hours as needed for agitation start date 12/19/23, Mirtazapine 15 mg by mouth at bedtime for major depression start date 12/20/23, Zolpidem Tartrate 10 mg by mouth every 24 hours as needed for insomnia start date 12/20/23. On 05/22/24, reviewed in R130's EHR Consultant Pharmacist's Medication Record Regimen Review dated 05/08/24, 04/03/24, 03/05/24, 02/06/24 with no recommendations. On 05/23/24, V2 provided copy of R130's Consultant Pharmacist's Medication Record Regimen Review dated 05/23/24 which documents in part, antipsychotics have the capacity to cause tardive dyskinesia and other movement disorders. AIMS TEST APPEARS TO BE DUE. Recommend movement test, such as AIMS or DISCUS, be performed initially (within 30 days), and then at least every six months while this resident continues on antipsychotic therapy. On 05/23/24, V2 provided copy of R130's Consultant Pharmacist's Medication Record Regimen Review dated 05/23/24 which documents in part please consider the following psychotropic PRN medications Haloperidol 2 milligram injection solution Quetiapine 25 milligram tablet, Lorazepam 1 milligram tablet, Haloperidol oral concentrate 2 milligrams per milliliter, Zolpidem 10 milligram tablet and REMINDER: PRN Psychotropic Orders are only valid for 14 days UNLESS OTHERWISE STATED ON MEDICATION ORDER. R3's Consent for Psychotropic Medications for Lorazepam Oral Tablet 1 mg, Haloperidol Lactate Oral Concentrate 2 mg/dL, Zolpidem Tartrate Tablet 10 mg, Zoloft Oral Tablet 50 mg, dated 05/20/24 and Consent for Psychotropic Medications for Haloperidol Lactate Injection Solution, Donepezil HCl Oral Tablet 5 mg, Lorazepam Oral Tablet 1 mg, Mirtazapine Oral Tablet 15 mg dated 05/20/24. R130's Psychiatry Progress Note dated 12/20/23 documents change in drug therapy is contraindicated at this time - past reduction attempts have resulted in psychiatric instability. No recent GDR (Gradual Dose Reduction) documentation found for R130 for antipsychotic medication use. (continued on next page)

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	145661	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ryze West	5130 West Jackson Boulevard Chicago, IL 60644

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/23/24 at 12:51 PM, V2 (Director of Nursing) stated she is the DON and the Psychotropic Nurse. V2 stated before starting any psychotropic medication or when changes are made in the dosage of a psychotropic medication a consent is needed which is entered onto a form electronically and kept in the resident's EHR. Psychotropic medications include medications for depression, anxiety, antipsychotics, sedatives. V2 stated an AIMS test should be done upon admission and then quarterly/annual and as needed and the purpose of the AIMS test is to see if the resident is having any involuntary movements. V2 stated the risk of the psychotropic medications is that they can sometimes cause damage to the body and the risk may not be worth taking. V2 stated sometimes the medication needs to be lowered, altered, or changed. A GDR should be done on the recommendation of the physician or pharmacist. V2 stated the goal is for the residents not to be on any psychotropic medications but some psychotropic medications cannot be stopped but a trial/taper can be done if the doctor orders it. V2 stated as needed or PRN medications are reviewed at 14 days. If they still need to be on them then the doctor needs to address the behavior if it is still happening. V2 stated the psychiatrist completes their documentation electronically and it can be found if available under the miscellaneous section of the EHR. V2 stated, we are trying to get another doctor and you've seen the charts. We are a work in progress. We are trying.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49486 Based on observation, interview, and record review the facility failed to ensure resident is free of significant medication errosr to 1 (R134) of 8 residents reviewed for medication administration resulting in administering 4 units of Humalog Insulin one hour before meal instead of with meal. This deficient practice has the potential to place R134 in Hypoglycemia distress. Findings Include: R134's electronic Medication Administration Record (eMAR) as at 5/2024 documents in part: Humalog Solution 100 Unit/ML. Inject as per sliding scale (251-300 = 4 units) subcutaneously with meals. R134's Minimum Data Set (MDS) dated [DATE] shows R134 is cognitively intact. On 5/21/24 at 11:43 AM, surveyor observed V39 (Licensed Practical Nurse/LPN) administering 4 Units of Humalog Insulin subcutaneously at Left Lower Quadrant (LLQ) to R134 before meal was served on the unit. When surveyor asked V39 what V39 should have done before administering the insulin. V39 stated V39 should have waited for the lunch tray to be served to R134. V39 stated V39 administering the 4 units of Humalog Insulin to R134 could lower the blood sugar of R134 and could cause R134 Hypoglycemia distress because it is a fast-acting insulin. On 5/21/24 at 12:45 PM, surveyor observed meal tray arriving on the second floor. On 5/21/24 at 12:55 PM, R134 eating lunch in the dining room. R134 stated R134 does not usually receive R134's insulin with meal even when R134 supposed to. On 5/22/24 at 10:50 AM, V2 (Director of Nursing) stated it is V2's expectation that the nurse will administer Humalog Insulin with meal. Administering Humalog Insulin without a meal is a medication error that can cause R134 to go into hypoglycemia, comatose or death. Documents reviewed but are not limited to: R134 Physician Order Sheet (POS) active order as of 5/22/24 documents in part: Humalog Solution 100 unit/ml, inject as per sliding scale, subcutaneously with meals for Diabetes Mellitus. Facility Meal Serving Time, documents in part: 2nd Floor Lunch at 12:30 PM Facility Medication Administration In-Service, Education and Staff Development, documents in part: All medications are administered safely and appropriately to aid residents to overcome illness, relieve, and prevent symptoms. Follow special instructions written on the label. Facility Insulin Injection Administration, documents in part: Follow Medication Administration Record/Doctor orders, if order state with meals the medication must be given with meals.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39779 Based on observation, interview, and record review the facility failed to a.) ensure medications were labeled when opened, b.) ensure expired medications were removed from the medication cart/medication room and c.) ensure medications for discharged residents were removed from the medication cart in 2 of 3 medication carts and 1 of 2 medication rooms reviewed for medication storage and labeling. Findings Include: On 05/12/24 at 10:28 AM the fourth-floor medication cart 1 was reviewed with V6 (Licensed Practical Nurse). Expired medications were observed in the top drawer of the medication cart including; Enteric Coated Aspirin 325 MG expiration date 09/23, Zinc 50 MG expiration date 01/24, Fish Oil 1000 MG expiration date 04/24, Vitamin E 450 MG expiration date 04/24, Acidophilus with pectin expiration date 03/24, Guaifenesin 400 MG expiration date 03/24, Vitamin B6 100 MG expiration date 02/24, Naproxen 220 MG expiration date 03/24 and Bisacodyl 5 MG expiration date 02/24. Surveyor asked V6 what is done when administering medication, V6 responded, check the MAR (Medication Administration Record), dosage and obviously check the date. I will give the expired medication to the manager and let them dispose of them. If expired medication is given the resident can get sick and it can affect the effectiveness of the medication. On 05/21/24 at 10:45 AM the fourth-floor medication room was reviewed with V7(Licensed Practical Nurse 4th floor Unit Manager). Expired medications were observed in the cabinet including Aspirin 325 MG expiration date 09/23, Vitamin B6 100 MG expiration date 02/24, Thera Multivitamin x2 bottles expiration date 04/24, Calcium 600 + D3 5 MCG (Microgram) expiration date 03/24 and Cranberry 450 MG expiration date 02/24. V7 stated central supply restock the stock medications. V7 was observed disposing of the expired medications in a container named drug buster. On 05/21/24 at 11:01 AM the second -floor medication cart 1 was reviewed with V8 (Licensed Practical Nurse). V8 stated I have worked here for [AGE] years. Medications that were opened without an open date was observed in the medication cart including: R25 Fluphenazine HCl Injection Solution Inject 2.5 ml intramuscularly one time a day every 21 day(s), R110 Latanoprost Solution 0.005 % Instill 1 drop in right eye Twice a day and Timoptic Solution 0.5% (Timolol Maleate) Instill 1 drop in right eye Twice a day, R100 Fluticasone-Salmeterol Inhalation Aerosol Powder Breath Activated 250-50 MCG/ACT 1 puff Twice a day and R98 Fluticasone Propionate HFA Inhalation Aerosol 220 MCG/ACT 1 puff inhale orally every 12 hours. Expired medications were observed in the top drawer of the medication cart including Vitamin B6 100 MG expiration date 02/24, Thera Multivitamin x2 bottles expiration date 04/24, Cranberry 450 MG expiration date 02/24 and Meclizine 12.5 MG expiration date 03/24. V8 stated when medication is expired it is disposed of in the medication buster and central supply will come and replace the medication. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/22/24 at 10:42 AM V2 (Director of Nursing) stated The nurse should be checking the expiration date of the medications because they cannot give expired medications. The expiration dates are checked on a daily basis and if the medication has expired it should be pulled off the medication cart/medication room and destroyed. If expired medications are given there is a potential that they may not know the strength of the medication anymore and it can be more potent or less effective. The nurse and the clinical team are responsible for checking to make sure expired medications are not in the medication cart and the medication rooms on the floor. Central supply brings up the house stock medications. Medications should be labeled and dated once opened with the opening and expiration date. That is the only way that they will know when it expired because medications like insulin expires based on when the seal is broken. On 05/23/24 at 11:31 AM V2 (Director of Nursing) stated when a resident is discharged from the facility the medications are sent with them. None of the resident medications should remain in the medication cart. In-Service, Education and Staff Development undated document in part: Topic: Medication Administration. All medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis. 11. Verify that the medication has not expired. In-service sign in sheet attached. Policy: Titled Medication Storage in the Facility reviewed 01/24 document in part: Medications and biologicals are stored safety, securely, and properly following the manufacture or supplier recommendations. 14. Outdated, contaminated, or deteriorated drugs and those in containers, which are cracked, soiled or without secure closures will be immediately withdrawn from stock by the facility. They will be disposed of according to drug disposal procedures, and reordered from the pharmacy if a current order exists.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46342 Based on observations, interviews, and record reviews, the facility failed to a.) ensure food items were labeled and dated with an opened and use by date, b.) discard expired or spoiled food, c.) keep food storage areas clean, d.) sanitize cooking equipment based on manufacturers' directions. These failures have the potential to affect all 176 residents receiving food prepared in the facility's kitchen. Findings include: On [DATE] at 8:57 AM, during initial kitchen tour V11 (Dietary Director) stated everything that comes into the kitchen must be labeled and date and when something is opened it needs to be labeled with the open date and use by date. V11 stated all refrigerated food needs to be used within seven days. V11 stated that even if the item is marked with a manufacturer use by date, the kitchen goes by seven days from when the item is opened, not the manufacturers use by or best by date for when the item should be thrown out. On [DATE] at 9:05 AM, observed the following in Refrigerator #2: 1.) Opened case of fresh strawberries dated [DATE] observed to shriveled, and some of the strawberries were covered in a white, light gray fuzzy material. V12 (Area Kitchen Manager) stated the strawberries looked dusty. V11 stated these strawberries would not be served to residents because they are passed the 7-day expiration time. 2.) Black/dark gray dust like material covering the refrigerator fan covers and the same black/dark gray material in clusters on the ceiling of the refrigerator. V11 stated the material looks like dust and it should not be there because it could blow on the food. On [DATE] at 9:25 AM, observed in Refrigerator #1 opened one gallon barbeque sauce dated with delivery date [DATE]. There was no open or use by date. V11 stated while the product had not expired based on the delivery date the item should be labeled with an opened date so the staff can keep track of how long the product is good for and know when to discard it. On [DATE] between 10:40 AM-12:00 PM, observed V22 (Cook) prepared pureed food items for lunch meal using an industrial blender. At 11:17 AM, observed blender container/lid/blade brought to the 3-compartment sink to be washed. V23 (Dietary Aide/Pot Washer) stated V23 has been working at the facility for [AGE] years. V23 stated there are 3 sections to the sink, wash in the first sink, rinse in the 2nd sink and sanitize in the 3rd sink. V23 stated the sanitizer in the 3rd sink is needed to make sure the items which are being fully cleaned and sanitized. At 11:22 AM, observed V23 wash blender container, then rinse and then dip blender container into the sanitizing solution for 11 seconds and remove and store on the side of the sink area. At 11:23 AM, observed V23 wash blender blade, then rinse and then dip blender blade into the sanitizing solution for 10 seconds and remove and store on the side of the sink area. At 11:24 AM, observed V23 wash blender lid, then rinse and then dip the blender lid into the sanitizing solution for 16 seconds and remove to store on the side of the sink area. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 11:25 AM, V23 stated when V23 is washing items V23 leaves them in the sanitizing solution for 10 seconds. V23 said, I count to 10. On [DATE] at 11:27 AM, V11 (Dietary Manager) stated the purpose of the sanitizing solution is to properly clean items to prevent cross contamination. V11 stated if the item if not kept in the sanitizing solution for the correct amount of time the item will not be fully sanitized. V11 stated the item(s) needs to be left in the sanitizing solution for the full minute (60 seconds) to sanitize. On [DATE] at 11:47 AM, observed V22 measuring out sweet potatoes and placing into the blender container with blade inside from the dish room area and cover with the blender lid and turn on the blender to puree sweet potatoes to desired consistency. On [DATE], facility provided list of diet orders for all residents in the facility printed [DATE] at 10:27 AM from the facility electronic health system. Diet order list indicates there are four residents receiving nothing by mouth (NPO). Facility provided policy titled Labeling and Dating Policy undated which documents in part, the purpose to assure the staff are using food that has not expired and meets food safety criteria, leftovers are to be used within 7 days and any items past the use by date will be discarded immediately. Facility provided policy titled Clean and Sanitary dated [DATE] documents in part all food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition and the Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner including floors, walls, ceilings, lighting, and ventilation. Facility provide policy titled QRT Three Compartment Sink dated [DATE] documents in part the dining service staff will be knowledgeable in proper techniques including for the third sink: submerge in the sanitizer sink for at least 60 seconds. Facility provided copy signage posted above the three compartment sink titled Pot and Pan Cleaning & Sanitizing Procedures dated 2021 which documents in part, submerge in sanitizer sink for ,d+[DATE] minutes.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 46342 Based on observation, interview and record review, the facility failed to ensure dumpster was covered to prevent the harborage and feeding of pests, insects, and rodents. This deficient sanitation practice has the potential to affect all 180 residents who reside in the facility. Findings include: On 05/21/24 at 9:37 AM, turning observation of outside dumpster with V11 (Dietary Manager) observed one large dumpster with two of the three lids wide opened. Also, observed debris and trash on the ground around the dumpster. V11 stated the lids should probably not be left open like that because birds and insects can get inside and feed off the garbage inside. V11 stated there should be no garbage on the ground near the dumpster. On 05/22/24 at 3:28 AM, V32 (Divisional Manager for Laundry and Housekeeping Services) stated the lids to the dumpster must be closed after putting garbage inside and there should be no debris or garbage on the ground around the dumpster. V32 stated the lids should be fully closed to keep rodents from getting in the dumpster because eventually this will lead a trail to the building. V32 stated we don't want rodents to be near the building because it is a health care facility, and it should stay as clean as possible. Facility provided kitchen policy titled, Dispose of Garbage and Refuse dated 09/01/21 documents in part, all garbage and refuse will be collected and disposed of in a safe and efficient manner and the Dining Services Director coordinates with the Director of Maintenance to ensure that the area surrounding the exterior dumpster area is maintained in a manner free of rubbish or other debris. Facility provided policy titled Clean and Sanitary dated 07/04/21 documents in part all trash will be properly disposed of in external receptacles (dumpsters) and then surrounding area will be free of debris.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50057 Based on observation, interview and record review, the facility failed to follow professional standards of practice and facility policy to prevent and control infection in the provision of patient care. This failure has the potential to affect all 180 residents in the facility. Findings On 05/21/24 at 9:13 AM V33 (CNA) was observed leaving room R121's room which had a sign for enhanced barrier precautions (EBP) on the door. V33 took the breakfast tray out of room , placed the tray in the return cart, did not perform hand hygiene and then entered room [ROOM NUMBER] which also had a sign for EBP on the door. V33 took the breakfast tray out of R162's room, placed it in the return cart, did not perform hand hygiene and began to push the cart down the hall. V33 was asked about the EBP signage. V33 stated It means that we gown up before doing care. We wear gown and gloves and use hand sanitizer before we put gloves on. If we are going to pass or pick up trays, we put gloves on. I didn't put gloves on. I should have used hand sanitizer before going into the room. On 5/21/2024 at 11:13 AM, R179 was observed to have a PICC line. No EBP signage was on the door of R179's room. On 05/21/24 at 2:50 PM, R70 was observed to have door signage for droplet precautions, contact precautions and EBP. The red bin for PPE disposal was observed to be located along the wall between bed 1 and bed 2 in the resident's room. During interview, V30 (LPN) stated that PPE should be donned in the hallway and doffed before exiting the room. While standing in the doorway, surveyor asked how PPE is disposed of in the red bin. V30 stated I don't know. We take the PPE off after we take care of R70 and dispose of it standing in front of the red bin and then wash our hands in the bathroom and exit the room. When surveyor asked if the location of the red bin for PPE disposal was located so that PPE was being doffed in a clean space, V30 stated no. On 05/21/24 at 3 PM, V34 (Infection Prevention Nurse) was interviewed and stated that staff should don PPE before entering the room and doff PPE in the doorway immediately prior to exiting the room. When surveyor stated that red bin to dispose of PPE is located between bed 1 and bed 2 in R70's room and that staff are reportedly doffing PPE in front of the red bin in the resident's room. V34 stated That is not correct. Staff have been told that they should remove their PPE in the doorway before exiting the room. I will take care of it. On 05/22/24 at 9:30 AM, V34 (Infection Prevention Nurse) was interviewed regarding infection prevention and control practices and stated that she performs surveillance and looks at healthcare acquired infections (HAI) monthly. Staff are reeducated as needed and the surveillance data is discussed at the monthly Quality Assurance and Performance Improvement (QAPI) meeting. V34 stated Last month, we had a 4.21% HAI. It was related to an increase in UTIs and soft tissue/wound infections. V34 stated that the initiation of EBP is based on criteria. An order is not needed. Residents with G-tube, dialysis, IV/PICC line, wounds, urinary catheters and tracheostomies should all be on EBP. V34 stated that if a resident is on EBP and staff are providing care, then PPE should be worn, which at a minimum is a gown and gloves. When staff are delivering or picking up food trays for patients on EBP, hand hygiene should be performed after picking up a food tray and before going into the next room. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/23/2024 at 1:40 PM, red isolation disposal container was observed to be located between beds 1 and bed 2 in R70's room. V34 (Infection Prevention Nurse) stated that staff know that is not correct. Policy titled IC-Enhanced Barrier Precautions (EBP) dated 1/2023 and revised 3/20/2024 was reviewed and stated in part: General: EBP expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Signage for Enhanced Barrier Precautions stated Everyone Must: Clean their hands, including before entering and when leaving the room.