STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145832	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ryze at the Ridge	6450 North Ridge Blvd Chicago, IL 60626

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to notify the physician and obtain a treatment order, failed to monitor and document the status of a wound, and failed to develop an individualized care plan to address the wound of 1 resident (R1) out of 2 residents reviewed for wound care. Findings Include: On 5/6/25 at 10:56 AM, observed R1 in her room alert and able to verbalize needs. R1 stated when she was admitted in the facility, she had a healing surgical wound on her abdominal area. R1 stated she had a hernia repair six months ago and it takes a while for the wound to heal because she is Diabetic. R1 stated that the surgical site re-opened sometime last month, and she notified a nurse (could not remember nurse's name). R1 stated that staff are not doing anything to treat her re-opened surgical wound. On 5/6/25 at 11:15 AM, V7 (Registered Nurse) was asked to check R1's surgical site on her abdominal area with this surveyor and noted a small, opened wound measuring approximately 0.5 centimeter in width around R1's naval area with no signs and symptoms of infection noted. The wound was open to air with no wound dressing. R1 stated that the opened wound rubs off on her clothes and get irritated. V7 stated the last time she saw R1's surgical site was last week, and it was scabbing with no open area. On 5/6/25 at 12:23 PM, V10 (Assistant Director of Nursing/Licensed Practical Nurse) stated that there is no wound care nurse in the facility. V10 stated she oversees and tracks pressure ulcers and surgical wounds in the facility and make rounds with the wound doctor weekly. V10 stated that there is no resident in the facility that currently has surgical wound. V10 stated she was not notified and has no information regarding R1's surgical wound. V10 stated that if a surgical wound is re-opened, the nurse should assess and call the doctor to get treatment order. Nurses will enter the physician's orders in the resident's chart and carry out the orders. V10 stated when treatment is done, the nurse should sign and document in the treatment administration record (TAR) and the progress notes. V10 stated that if it's not documented or signed off, it means it's not done. If treatment is not done for any type of wound, there is a risk for infections. V10 stated opened wounds should be monitored and documented in the resident's chart if it's healing or getting worse. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/6/25 at 12:41 PM, V2 (Director of Nursing) stated that if resident is admitted with a surgical wound, nurses should monitor the site even if it's healed especially if the resident is new to the facility. The nurse should assess and call the doctor to get treatment order if the wound re-opened. The orders are entered in [electronic health record] and TAR and document in progress notes the assessment and what was the intervention. V2 stated nurses are supposed to check and monitor the wound at least daily until healed. They would document in progress notes the condition of the wound, if it's healing, or if it is getting worse. Treatments done are signed off in the TAR. On 5/6/25 at 2:00 PM, V7 (Registered Nurse) stated that R1's healing skin on her surgical wound peeled off (does not remember the exact date). V7 stated she cleansed the area with normal saline and applied bandage, so R1 won't scratch it. V7 stated she did not notify R1's doctor. V7 stated she notified V10 (Assistant Director Of Nursing/Licensed Practical Nurse) . V7 stated, I put it on the communication board in the computer to notify all the staff. I did not call the doctor. The wound did not look infected. It was not red. No drainage. No pus. She was not complaining of pain. On 5/7/25 at 10:28 AM, V20 (MDS Coordinator) stated that if a resident is at risk for skin breakdown and if there is current wound, it should be addressed in the care plan. If they have acquired wound the care plan should be updated when it has been identified. Residents who were identified with new skin breakdown should be communicated in the electronic health records for all the staff to see and the care plan will be updated as soon as possible. V20 stated that the care plan shows what the staff will do for the resident, what problems they are exhibiting and the interventions on how to address the problems. The care plan goal is to help the staff complete the process. V20 stated that she was notified just last night about R1's surgical wound. V20 stated, I check the communication board every day for any updates with the residents. I was not notified of her [R1] healing surgical wound until last night. 5/6/25 at 1:09 PM, surveyor requested a list of residents with current skin breakdown. The facility provided a list with one resident currently have vascular wound and R1 was not included on the list. R1's clinical records show an admission date of 4/7/25 with included diagnoses but not limited to type 2 diabetes mellitus and cirrhosis of liver. R1's Minimum Data Set, dated [DATE] shows R1 is cognitively intact. R1's progress notes dated 4/7/25 at 6:31 PM documents R1 was admitted in the facility and was noted with a surgical scar on the abdomen. R1's progress notes on 4/17/25 at 9:31 PM, V7 documented in part: [R1] called NOD [Nurse on Duty] to come to her room. On getting to the resident room, resident asked the NOD to take a look at the incision site at the upper middle of the navel. The site was assessed with a little round dry scar that peeled off. Site was cleanse with normal saline and kept dry. Resident request bandage for the site, resident was remind that the site doesn't need bandage for now, that it needs a bit of air to make the surface dry, resident became agitated. Resident was reminded that the wound nurse will assess the site. Wound nurse was notified to see the resident. R1's physician orders and TARs from 4/17/25 to 5/5/25 revealed no treatment order for R1's surgical wound. R1's comprehensive care plan does not have an individualized care plan addressing R1's surgical wound with measurable goals and interventions. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's CHANGE IN RESIDENT CONDITION policy dated 1/25 documents in part: It is the policy of the facility, except in a medical emergency, to alert the resident, resident's physician and resident's responsible party of a change in condition. Nursing will notify the resident's physician or nurse practitioner when: It is deemed necessary or appropriate in the best interest of the resident. The resident's care plan will be updated as appropriate. The facility's SKIN MANAGEMENT: Monitoring of Wounds and Documentation policy dated 1/25 documents in part: It is important that the facility have a system in place to assure that the protocols for daily monitoring and for periodic documentation of measurements, terminology, frequency of assessment, and documentation are implemented consistently throughout the facility. The facility's COMPREHENSIVE CAREPLAN policy dated 3/17/25 documents in part: The facility must develop a comprehensive person-centered care plan for each resident. The care plan will include a focus, measurable goal, and interventions specific to the resident's medical, nursing, mantal, and psychosocial needs.