STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146132	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ryze at Homewood	19000 South Halsted Homewood, IL 60430

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 - 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** 40987 Based on interview and record review, the facility failed to ensure physician orders for daily wound care treatments were completed as ordered; failed to ensure daily monitoring of a wound for presence of possible complications such as signs of increasing area of ulceration or signs of soft tissue infection; and failed to ensure care plan interventions for alteration in skin integrity were implemented for one (R1) of four residents reviewed for wound care. These failures resulted in R1 developing a worsening coccyx pressure ulcer and require transfer to a local hospital with a diagnosis of septic shock due to pressure wound infection requiring admittance to the intensive care unit for five days. Findings include: R1 is [AGE] years of age. Current diagnoses include but are not limited to Cerebral Infarction, Pressure Ulcer of Sacral Region, Obesity, Type 2 Diabetes Mellitus, and Hypertension. R1 was originally admitted to the facility from the hospital on 1/8/25. R1's admission assessment documents a community acquired sacral wound. R1's comprehensive assessment section C cognitive status dated 1/15/2025 documents a brief interview for mental status score of 15 out of 15. A score of 13-15 indicates the person is cognitively intact. Review of R1's records document the following: R1 was admitted to the facility on [DATE] from the hospital. R1's admission assessment documents a sacral wound. The MDS section M documents R1's unstageable sacral wound. R1's 1/9/25 lab results for the WBC (White Blood Cell) count was 13.62 (H) High. The white blood cell count is a measure of the number of white blood cells circulating in the blood stream. [NAME] blood cells are essential for the immune system, playing a crucial role in fighting infections and other threats in the body. The reference (normal) range for adults per the lab result is 4.80 - 10.80. A high white blood cell count also known as leukocytosis, can occur due to a number of possible reasons, including infections, inflammation, or bone marrow disease. (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 - Actual harm Residents Affected - Few	R1's care plan states: R1 has alteration in skin integrity to coccyx- unstageable. Date initiated: 01/09/2025. Goal: R1 will be free from complications through next review date. Interventions: Assess wound with each dressing change. Date initiated: 01/09/2025. Monitor for infection: Peri-wound erythema (redness)- Increased drainage and odor- Increase pain- Peri-wound swelling- Exposed bone- Pressure wound deterioration. Date initiated: 01/09/2025. Treat as ordered by MD. Date initiated: 01/09/2025. V9 Wound Physician's 1/21/25 wound evaluation and summary states in part: stage: unstageable DTI (deep tissue injury) within and around wound, wound size (Length x Width x Depth): 15.5 x 20 x 0.1) cm centimeters, exudate: light sero-sanguinous (wound drainage secreted by an open wound in response to tissue damage), wound progress: exacerbated due to generalized decline of patient. Additional wound details: patient with significant wound decline, patient with poor po (by mouth) intake, concern for possible skin failure, if no plans for aggressive interventions i.e. g-tube (gastrostomy/ stomach tube) etc., would consider hospice referral. On 1/10/25, V3, Wound Care Nurse, documents an unstageable coccyx wound measuring 5.0 cm x 1.0 cm x undetermined with light serous drainage. Wound has 75% slough. The wound care order documents clean sacrum with normal saline cover with dry dressing q shift, every day shift for open area and as needed for when wet. V10, NP/Nurse Practitioner's, 1/11/25 progress note states: Patient is compliant with care, dietary, and medication regime. Labs 13.62. Assessment/Plan- monitor labs as ordered. V9, Wound Physician's, note from 1/14/25 states: unstageable coccyx full thickness wound. Etiology (cause): pressure. Noted to be present on admission per staff. R1 underwent a surgical excisional debridement procedure (surgical procedure that involves removing dead or infected tissue from a wound). Dressing treatment plan: Leptospermum honey apply once daily for 30 days. Gauze island with border apply daily for 30 days. V11 Physician's 1/15/25 progress note states: Labs reviewed. Skin: see wound care note for assessment. V8, RN's, 1/21/25 at 11:36 AM, progress note documents, writer received resident in bed resting. Resident was drowsy, responsive to tactile stimuli only, tachycardia noted, hypoxic, and sacral wound has purulent drainage. Primary physician was contacted for recommendation. Resident was sent to hospital via transportation escorted by two EMT (Emergency Medical Technicians). Last vitals, BP blood pressure 140/68, HR heart rate 105, BS blood sugar 133, O2 (oxygen) on 2L (liters) nasal canal 94%. On 1/21/25 R1 was sent to the hospital emergency department and was admitted for septic shock due to a sacral pressure wound infection. R1 was admitted to the ICU (Intensive Care Unit) until 1/26/25 (5 days). V2, Director of Nursing/DON provided R1's 1/1/25 - 1/31/25 electronic treatment administration record. There is no documentation of R1 receiving the prescribed wound care treatments from 1/8/25 through 1/12/25. There is no documentation of the wound care treatment being completed on Saturday 1/18/25. V3, Wound Care Nurse, documented completing R1's treatment on Wednesday 1/22/25, while R1 was admitted to the hospital intensive care unit. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R1 was sent to the hospital on 2/8/25 by family request, and did not return to the facility during the investigation. On 2/18/25 at 1:46 PM, V3, Wound Care Nurse, said, I think she came from the hospital with her wound. She admitted here with an unstageable wound to her coccyx area. I did her wound care Monday through Friday. The floor nurses did it on the weekend. On 2/18/25 at 3:10 PM, V6, LPN/Licensed Practical Nurse, said, I work every other weekend. If (V3, Wound Care Nurse) isn't here we're responsible for our resident's wound care. (V3) stocks all the wound care supplies in the carts on Friday. I try to do the dressings changes during the CNA(Certified Nurse Assistant) rounds. On 2/19/25 at 12:03 PM, V8, RN/Registered Nurse, said, I had (R1) for day shift. I float through the building, so I wasn't familiar with her. I didn't get anything concerning in report about her that morning. She was tachycardic (fast heart rate) and her blood pressure was up. Her vitals were accurate as I documented. The aide said she wasn't eating well. She was drowsy. Her wound looked to have some infection; the drainage was thick, yellowish color. I can't recall if it had any odor. (R1) didn't complain of any pain. On 2/19/25 at 12:38 PM, V3, Wound Care Nurse, said, I think she was admitted on [DATE]th sometime that evening. When I came in January 9th, I pulled the admission report to see if we had any new admissions. I went to see her, and she refused. I thought I charted it, but it's not there. January 10th, she allowed me to do a skin assessment. She had a unstageable wound with slough. I don't recall it having any purulent drainage or odor. V3 was asked what were R1's admission orders for wound treatment? V3 said, Clean with normal saline and cover with a dry dressing. V3 was asked where were R1's wound treatments documented? Why is the treatment administration record blank from 1/8/25 - 1/12/25? V3 said, It's supposed to be documented in the TAR (treatment administration record). When a treatment is done it's supposed to be documented. Not sure what happened. V3 said, I'm with the doctor when she comes on Tuesdays. The next day the doctor would have seen her was on January 14th. The treatment ordered was Medi honey with a bordered gauze daily. She had a debridement; the doctor removed the layer of slough from the wound. (R1) tolerated the procedure. V3 was asked about the assessment of R1's wound on 1/21/25. V3 said, The wound care doctor was here and saw R1 that day. The wound declined. There was light serous exudate (wound drainage). When did you become aware of R1 being hospitalized and what was her admission diagnosis? V3 said, I don't know when (R1) went to the hospital. What did you assess during R1's wound treatments from 1/15/25 - 1/21/25? V3 said, I think she had a change in size and appearance. If a wound is infected, you'd see peri wound changes, purulent drainage, heat around peri wound, redness. I didn't see any of this in her wound. V3 confirmed the TAR for 1/1/25 to 1/31/25 was missing documentation of R1's wound care treatments. R1's wound care treatments were not performed as ordered by the physician. V3 and nursing staff did not monitor R1's wound for the presence of possible complications or presence of infection. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 2/19/25 at 1:21 PM, V2, Director of Nursing/DON, was asked about the policy regarding following physician orders for wound care treatments. V2 said, You get the order from the doctor and carry it out per they physician order. I sign out the order that it's completed on the TAR (treatment administration record). Documenting confirms that the treatment was done. There's no signature on the yellow spaces on the TAR. No one signed the treatment out. It's not completed. V2, DON, continued, (R1) had labs done when she was admitted , and her WBC (White Blood Cells) were elevated already. The in house NP, (Nurse Practitioner, V10) and (V11, Physician) saw (R1) that week and said to monitor (R1) since she was asymptomatic. (V10's, NP), 1/11/25 note she documented (R1's) leukocytes as 13.62, she only put continue to monitor in her assessment. (V3) told me (R1) had some slough and (V9, Wound Physician) did a debridement. She had poor intake, and she was refusing wound care multiple times. V2 was asked about documentation of refusing wound care. V2 said, It should be in the progress notes. V2 was asked who is responsible for completing the wound care treatments when V3 is not in the facility? V2 said, The nurses are assigned the treatments per the treatment schedule and it's posted on the dash board in PCC (point click care electronic medical record). The nurses are to complete the treatments and document. V2 confirmed R1's TARs were documented, and the wound treatments were not performed as ordered by the physician. V2, DON, provided 36 pages of R1's progress notes from 1/8/25 - 1/23/25. There was no documentation of R1 refusing wound care treatment multiple times. V2 provided a care plan, initiated for R1 on 2/3/25, documenting refusal of care after her hospitalization for septic shock due to sacral pressure wound infection. On 2/19/25 at 3:00 PM, V9, Wound Physician, said, She had a wound on her bottom with clinical decline. She needed a debridement. I wasn't aware of her elevated WBC (White Blood Cells- lab value). I wasn't informed because I didn't order them. Her wound was significantly larger, much bigger than my debridement and the tissue looked different. It was a deep purple color. I don't remember it having drainage. She wasn't very responsive about having pain. When I saw her on January 14th, I wanted them to contact her primary doctor because she looked different. It wasn't necrotic, it was a deep dark purple color. When I see a wound declining that means something else is going on inside, something clinically was going on with her because her wound had a dramatic change. Everything was documented in the notes. On 2/20/25 at 1:37 PM, V1 was asked about the expectation of the wound care and nursing staff when a resident has physician orders for wound care treatment. V1 said, For the wound care nurse and nursing staff to carry them out and chart the documentation. It's important because it's a part of the resident's medical record and shows that we completed the physician's orders. The 1/2024 reviewed Skin Management: Monitoring of Wounds and Documentation policy states: General: 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. Responsible party: All nursing staff (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	General Guidelines: An evaluation of the PU (pressure ulcer)/ PI (pressure injury) if no dressing present; An evaluation of the status of the dressing, if present (whether it is intact and whether drainage, if present, is or is not leaking); The status of the area surrounding, the PU/PI (that can be observed without removing the dressing); The presence of possible complications, such as signs of increasing area of ulceration or soft tissue infection (for example: increased redness or swelling around the wound or increased drainage from the wound); and whether pain, if present, is being adequately controlled. General Monitoring Guidelines: With each dressing change or at least weekly (and more often when indicated by wound complications or changes in wound characteristics), an evaluation of the PU/PI should be documented. At a minimum, documentation should include the date observed and: location and staging; size (perpendicular measurements of the greatest extent of length and width of the PU/PI, depth; and the presence, location and extent of any undermining or tunneling/sinus tract; exudate, if present: type (such as purulent/serous), color, odor, and approximate amount; Pain, if present: nature and frequency (e.g. whether episodic or continuous); Wound bed: color and type of tissue/character including evidence of healing (e.g. granulation tissue), or necrosis (slough or eschar); and description of wound edges and surrounding tissue (e.g. rolled edges, redness, hardness/induration, maceration) as appropriate.