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	06/04/2025

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 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to monitor and document a dependent resident's fluid intake for all meals that required one to one supervision during meals and failed to assess for signs and symptoms of dehydration. This affected one of four residents (R1) reviewed improper nursing care and dehydration. This failure resulted in R1 being emergently transferred to the hospital and diagnosed with severe hypernatremia (excessively high sodium level in the blood) and AKI (Acute Kidney Injury). R1 was hospitalized for 5 days requiring intravenous fluids and antibiotic treatment. Findings include: R1 is [AGE] years of age. Current diagnoses include but are not limited to Cerebral Infarction, Dementia, Type 2 Diabetes Mellitus, Hypertension, Hypernatremia, Epilepsy, and Hyperlipidemia. R1's comprehensive assessment section C cognitive patterns, dated 3/31/25, documents a Brief Interview for Mental Status score of 9 out of 15. R1 had moderate cognitive impairment. R1 was initially admitted to the facility on [DATE]. R1's lab results from 4/7/25 indicate a sodium level of 158 H (high). R1's diet order, dated 3/31/25, states: Low Concentrated Sweets Diet Mechanical Soft texture, Thin consistency, 1:1 supervision at all meals. R1's progress notes document him being seen by V11, Nurse Practitioner on 4/17/25. There were no concerns documented regarding the elevated sodium level. There is no area in the electronic charting to document the amount of fluid being consumed by each resident. R1 does not have any fluid intake documentation in his electronic documentation upon review. R1's care plan states: R1 has Alzheimer's Dementia and may display moods/behaviors related to diagnosis. Interventions state: do not rush resident. Provide adequate time during resident care and meals. R1 is as risk for alteration in fluid volume related to disease progression. Interventions state: Encourage fluid intake. Monitor resident for early signs and symptoms of dehydration: thirst, loss of appetite, dry skin, dark colored urine, fatigue. (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 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R1's progress notes from 4/20/25 at 6:55 AM state: Contact person made aware of the change in health condition and transfer to the hospital. R1's progress note on 4/20/25 at 7:29 AM states: The resident was lethargic around 6:48 am when the staff went to clean him up. On assessment, BP (blood pressure) 124/93, H (heart rate) 133, R (respirations) 24, T (temperature) 98.6, SP02 (pulse oximetry) 94 RA (room air). Plan to send resident to ER (emergency room) for further evaluation. R1's progress note on 4/20/25 at 10:16 AM states: Per ER (emergency room) RN (Registered Nurse) resident is being admitted for sepsis, acute kidney injury, elevated WBC (white blood cell count) 13.9 and abnormal labs (Sodium 177, BUN 60, Lactic acid 2.1, and Creatine 2.65). R1 was admitted to the hospital with severe hypernatremia (excessively high sodium level in the blood), AKI (Acute Kidney Injury) lab values- creatinine 2.65 suspected secondary to dehydration. (Creatinine is a waste product of muscle metabolism that is normally filtered out of the blood by the kidneys. A high level may suggest kidney damage.) Abnormal laboratory values, elevated troponin level in the blood (damage to the heart muscle), pyuria (presence of abnormally high number of white blood cells or pus in the urine) and hematuria (presence of blood in the urine). Patient initiated on IVF (intravenous fluid) rehydration and IV antibiotics and will be admitted for further workup and management with nephrology on consult. R1's 4/20/25 nephrology consult states: assessment/plan- AKI Acute Kidney Injury secondary to relative hypotension and poor po (oral) water intake. R1 was hospitalized for 5 days. He returned to the facility on 4/25/25, with physician orders to continue oral antibiotics for another 14 days. R1 died in the facility on 5/14/25. On 6/2/25 at 10:43 AM, the secured unit was observed. There was a water station set up with a large container with iced water and cups. Multiple residents were seated at the tables during a coloring and music activity, and only a few have cups of water. On 6/2/25 at 10:46 AM, V3, CNA/Certified Nurse Assistant, was asked about providing hydration. V3 said, Activities does hydrate the residents with juice, snacks, and coffee. We give out water throughout the day. The resident's swallow precautions are on the meal plan and on our charting. V3 was asked about providing care for R1. V3 said, (R1) was on a pureed diet with regular liquids. He had a hard time seeing, so we had to feed it to him. He would spill liquids and make a mess with his food, so we started helping him. His family would come in 2-3 times a week and help with feeding him. I didn't notice him decline when he was sent to the hospital. On 6/2/25 at 11:01 AM, V4, Activity Assistant, was asked about providing hydration. V4 said, I provide snacks and water throughout the day. V4 was asked about R1's hydration. V4 said, (R1) needed help because he couldn't see it all the way. How much he drank would depend on the day and who was helping him at the time. Some people leave if he stopped eating or drinking. I try to come back and finish helping him because sometimes he may forget he has something to drink or eat. I'm a CNA too, for 47 years. He declined a little before he went to the hospital. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 6/2/25 at 12:14 PM, lunch was being served. The meal was meatballs, rice, broccoli, cookie, and 4 oz fruit punch. Water was not provided by staff during the lunch meal to any of the residents eating in the dining room. Each resident's lunch tray was provided a 4 ounce cup of fruit punch. On 6/3/25 at 9:07 AM, V7 said, Most cups are 8 ounces. With breakfast, the residents get 8 ounces of juice and a 8 ounce carton of milk. About 10AM, we pass out ice water. Most of the residents drink whatever we give them. Some drink coffee. The residents that need assistance, I try to sit them close together so it's easier to get to them. We have to stay with them and make sure they drink their cup. We pick up their trays and see much they eat. I've been here 10 years. I remember what they eat. If they don't eat their usual, I know something's going on. We have to pay attention to them. We have to chart it in the computer. On 6/3/25 at 9:27 AM, V8, LPN Licensed Practical Nurse, was asked about resident hydration and intake documentation. V8 said, Most residents on this unit have Dementia or Alzheimer's, and some have high behaviors. They need assistance with ADL's (activities of daily living). We have a few residents who need to be fed. We have staff in the dining room monitoring every 30 minutes. They do activities and provide snacks and beverages. We have a water pitcher, and we give them water every 2 hours. The CNA's (Certified Nurse Assistant) have to monitor how much the resident's intake and chart it. The feeder residents need more attention with meals, and staff is responsible for making sure they're drinking between meals. The nurse makes sure the CNAs charting is done. We have unit managers that come check daily. I come in and assist them when the trays come down. The trays have a ticket with the resident's name and diet to make sure each resident gets the right tray. The aide would have to remember what each resident ate and drank. I don't know about their charting; you'd have to ask a CNA. V8 was asked about R1's hydration and documentation. V8 said, Some days (R1) needed encouragement and other times he'd need to be fed. Most of the CNA's got him up in the dining room. He had vision issues, so we'd have to give him his spoon and tell him where things were on his tray. Someone would have to put his cup in his hand and tell him he had a cup with something to drink. We had to get close to him so he could hear us because his hearing wasn't that good. Before he went to the hospital, he needed more assistance with feeding, and he was talking less. On 6/3/25 at 10:25 AM, V4, Activity Assistant, and V9 passed out 4oz cups of water to the residents in the dining room. At 10:45 AM, residents are seated at the table with water in front of them. Staff were not encouraging residents to drink water. On 6/3/25 at 10:54 AM, V10, Restorative CNA, was asked about resident hydration and intake documentation. V10 said, We can do the meal percent of what they eat for each meal. There should be a way to document the fluid intake. I haven't used the system in a while. On 6/3/25 at 11:25 AM, V7 was asked about documenting a resident's fluid intake. V7 said, There's no place to document the fluids, it's only the amount of food eaten. It's a new charting system since January when the new company took over. On 6/3/25 at 11:27 AM in the dining room, V7, CNA, asked V9, CNA, if there was a place to document the resident's fluid intake in the electronic charting. V9 said, No. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 6/3/25 at 12:12 PM, lunch arrived. The meal was smothered pork chop, carrots or corn, baked potato, Jello, and 4 ounces of juice. Water was not provided by staff during the lunch meal to any of the residents eating in the dining room. On 6/3/25 at 1:19 PM, V5, Registered Nurse, was asked about R1's condition and care. V5 said, I've been working there 2 years, but I don't have a set unit. It was my first time working with (R1). The CNA called me to his room. I don't remember who it was. The CNA said his upper arms were very warm and his legs were cold, so I went in to assess him. I found him tachycardic. The CNA said he wasn't the same as he usually was. I called the doctor, but couldn't get a hold of him right away. I raised his head of bed and did all the vital signs. All the other vitals were OK. I called the Director of Nursing and told her what was going on, and she said it was OK to send him out. I notified the family and called the ambulance. I felt something was going on because his heart rate was so high, so I sent him out for further evaluation. On 6/3/25 at 2:15 PM, V12, CNA, was asked about assisting R1 with care, hydration, and meals prior to him being hospitalized on [DATE]. V12 said, I remember (R1). I helped clean him up that morning before he went out. He was really tired. I got him up and he ate a little breakfast, not too much. He ate just a little at lunch too. It was almost change of shift, and (V14, Family Member) helped me put him in bed. (V14) was there when I changed him. He was wet with urine. He was different than his normal, really tired. (V14) said the same thing. He definitely had some changes that day. He usually has a good appetite, he'll eat everything. He was a total assist with everything, so I fed him. I think he was blind. I'd have to hold the spoon and cup for him. He'd follow commands and respond if he didn't like something. On 6/4/25 at 10:59 AM, V15, Dietician, was asked about fluid intake monitoring and R1's diet. V15 said, I started working with (R1) in May related to his wounds. I only followed him for one week before he died. He was diabetic and had dementia that was progressing. He was underweight, so I ordered a sugar free supplement. He was on a mechanical soft diet with thin liquids. His order was supervision at all meals, but I had just started working with him so I'm not quite sure when it was ordered. Staff should record the percentage of food eaten after each meal, the same with fluids too. It's important because residents with impaired cognition have PO (oral) intake that varies with each meal. Documentation is important because there is a risk for dehydration. Residents forget to drink; they have a decreased instinct to drink water. Staff should encourage and set out hydration. I wasn't aware the facility wasn't documenting fluid intake. On 6/4/25 at 11:52 AM, V2, Acting Director of Nursing, was asked about fluid intake monitoring, documentation, and R1's diet order. V2 said, I am the nurse consultant for the facility. I'm filling in until the new Director of Nursing starts. I'm not familiar with (R1). The CNAs are to monitor how much the residents are eating and report to the nurse if they aren't drinking. They can use the meal ticket to document how much they ate and transcribe it to (electronic documentation). I'll have to check the CNA charting, I'm not sure what they can chart. The facility policy on meal and fluid intake and documentation was requested. V2 did not provide a facility policy for review. The facility assessment is uesd to determine what resources are necessary to care for residents competently during daily operations and emergencies. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The updated December 2024 facility assessment states:(the facility is licensed to care for residents with the following) diseases/conditions, physical and cognitive disabilities - Alzheimer's Dementia, Hypertension, Seizures (Epilepsy), Diabetes. General Care- Nutrition: Specific Care or Practices: individualized dietary requirements, fluid monitoring. Assistance with activities of daily living: eating (independent, assist of 1-2 staff, and dependent residents). Staff type: Nursing services (DON, ADON, RN Supervisors, RN, LPN, CNA, etc.). Food and Nutrition Services (Director, support staff, Consultant Registered Dietician). Training topics: Licensed nursing staff: identification of resident changes in condition- identify medical issues appropriately, how to determine if symptoms represent problems in need of intervention, how to identify when medical interventions are causing rather than helping relieve suffering and improve quality of life. Non-licensed nursing staff- care of resident with Dementia. Competencies: Non licensed nursing staff: measurements- recording intake. The undated Registered Nurse/ Licensed Practical Nurse job description states: Basic function: under the direction of the physician, is responsible for total nursing care to all residents on assigned unit during the assigned shift including responsibility for delegation of duties, resident nursing care, staff performance and adherence by staff members to facility policies and procedures. Essential duties: 2. Implement total nursing care plan through assessment, planning, and evaluation. 9. Recognize significant changes in the condition of residents and take necessary action. The undated Certified Nurse Aide job description states: Basic function: To provide assigned residents with routine daily nursing care in accordance with established nursing care procedures, state, and federal guidelines, and as directed by your supervisor. Essential Duties: 19. Observe and report any physical or emotional changes observed in the residents including any complaints or grievances made by the resident. 20. Prepare resident for meals, assist serving food trays or feed as necessary and record/or report residents' intake or acceptance of food.