STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004832	A. BUILDING: _____ B. WING _____	08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RYZE WEST	5130 WEST JACKSON BOULEVARD CHICAGO, IL 60644

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Annual Licensure Certification Survey & Complaint Survey: 2386192/IL162486	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)6 Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part.. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These Requirements were not met as evidenced by: Based on observation, interviews and record reviews the facility (A) failed to ensure the safety of residents by not monitoring and preventing a resident [R125] with a document history of drug usage and drug overdose from obtaining and using an illegal drug. This failure resulted in R125 overdosing on heroin, requiring transfer and treatment to local hospital for treatment. (B) failed to follow smoking safety policy by not ensuring smoking materials are kept by facility or designated staff members for 4 (R82, R113, R118 and R413) residents and ensure that residents who smoke will be evaluated quarterly and annually for 2 (R113, R118) residents. These failures can potentially affect 4 (R82, R113, R118, R413) of 5 residents reviewed for smoking in the sample of 32.	S9999		

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S9999	Continued From page 2 Findings include: During review of R125's clinical record on 8/15/23 at 11:05 AM, documents in part: R125 is a 57-year-old admitted on 4/28/23, with medical diagnosis of opioid abuse, opioid dependence, poisoning by heroin encounter, nicotine dependence, paraplegia, acute kidney failure, essential hypertension, anxiety disorder, need for assistance with personal care, morbid severe obesity, localized edema, and muscle weakness. R125's record review indicates (prior to R125's admission) on 4/11/23- Hospital history and physical- R125's admission diagnosis-Opioid overdose. R125 reported to physician that [R125] bought some heroin from someone in the nursing facility, which R125 took. R125 minimum data set [MDS] brief interview score=15, indicates R125 is cognitively intact. 5/3/23 at 6:31 PM- Social Service Note-Social worker met with R125 and R125's family who brought in food, which had contraband in it for R125. Policies were reviewed for R125 and family member. R125's Care plan indicates: - 5/27/23- R125 has a substance abuse problem within the community. -5/2/23- R125 is unable to leave independently on community pass due to physical limitations. R125' Record Review progress notes- Documents in part indicates: 6/10/23 at 8:07 PM- Nurse Note-During rounds nurse observed R125 smoking in bed while laying down. R125 refused to put the cigarette out. Nurse presented R125 with a behavior contract.	S9999		

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S9999	Continued From page 3 R125 refused to sign it. Nurse notified social services department. 7/14/23 at 2:59 PM, Nurse Note-During wound care the nurse observed a small plastic bag with a powder substance and straw. R125 was alert and oriented x3 but appeared to be inebriated at the time. Nurse observed a plastic cup on the nightstand with cigarette ashes in the cup. All items given to unit manager. 7/15/23 at 2:03 PM, Nurse Note- Nurse providing care to R125, observed small clear plastic bad containing a white powdery substance along with a straw beneath him [R125]. R125 denied the bag belonged to him. Nurse reminded R125 of the contract he signed, R125 continue to deny that substance belonged to him. Nurse made social worker and director of nursing aware. 7/24/23 at 12:30 PM, Nurse Note- Staff informed writer that R125 was unable to arouse during wound care. Nurse immediately entered room and observed R125 unresponsive. Rapid response initiated, 911 called. Given previous behavior and past medical history Narcan x2 was given. R125 aroused and became verbally aggressive toward the staff members. 911 arrived and transported R125 to the emergency department. Nurse practitioner and management made aware. 7/24/23 Hospital history of present illness- R125 presents to the emergency department from nursing home after being opioids specifically heroin by family members or friends. Diagnosis: Cellulitis, Decubitus, and Opioid overdose, Patient Instruction-Narcotic Abuse Progress noted dated 7/24/23 at 12:30 PM,	S9999		

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indicated staff made V39 aware that R125 was not arousable during wound care. V39 went immediately to R125's room and observed R125 unresponsive. The rapid response initiated, 911 was called. Due to R125's previous behavior and past medical history, Narcan was administered two times. V39 initiated sternum rubs and R125's name, then R125 aroused. R125 became verbally aggressive toward staff members. 911 arrived on the scene and transported R125 to the hospital successfully. Nurse practitioner and administration was notified.

On 8/15/23 at 12:19 PM, V14[Director of Social Service] stated, "I been working here at this facility since 2019 left and came back here in 2022. R125 was admitted to this facility from a hospital, due to R125 overdose at another nursing facility on heroin. We accepted R125 under strict guidelines. Upon admission R125 agreed and signed to participate in the DUET program here at this facility. The DUET program is for residents with a drug and or alcohol abuse diagnosis. When R125 was admitted here I completed an interview. R125 told me, that he was not a drug head, and he did not overdose on drugs. R125 said he was depressed and got a hold of something bad and ended up in the hospital. R125 agreed and signed the Duet contract which indicates no visitors and no community pass for 14 days. R125 violated the contract in a week of admission. R125 had a family member come to the facility to sneak in. Next, R125 was seen smoking in his bed. R125 then entered into a behavior contract. R125 then ordered a knife from the internet and was delivered to the facility. The knife was given to R125 family member. R125 was not able to attend group meetings with the Duet program because he was in the bed most of the time, due

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to him being paralyzed. I set R125 up with one -to -one therapy sessions. When the counselor would come, R125 would refuse to meet with the counselor. On 7/24/23 R125 was found by V13 [Wound Nurse] unresponsive. The staff nurse V38 [Licensed Practical Nurse] administered R125 Narcan three times, before R125 came around and responded. R125 was sent to the emergency room. R125 has serval family members that will come visit without authorization. One family member snuck on the floor and told the nurse that the ADON [assistant director of nursing] gave the family member permission, but the ADON said she did not give permission. On 7/13/23, I met with R125 regarding him smoking in bed, and asked for his smoking materials. R125 refused and told me there is nothing anyone can do about it. R125 further said he would continue to smoke. I explained to R125 he would enter another behavior contract and visitors will be restricted. Also, I explained due to him [R125] not wanted to adhere to the facility policies I would send out referrals to other facilities. R313 which was R125's roommate admitted to me that he [R313] will go to the gas station to purchase cigarettes and lighter for R125. Prior to R125 overdosing on 7/24/23, there have been paraphernalia found in R125's bed, such as small packets with white power substance in it and cut up short straws. I had a strong suspicion that R313 was going out and bringing R125 drugs. R313 also have a history of drug addiction as well. On 7/15/23, R313 admitted to another social worker that R125 gave him money for drugs and he [R313] would go to the gas station and purchase cocaine or heroin whatever he could get his hands on for himself [R313] and R125. At that time R313 entered a behavior contract, R313 agreed not to purchase and bring drugs into the facility."

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S9999	Continued From page 6 During review of R313's clinical record on 8/15/23 at 1:00 PM, documents in part: R313 is a 60-year-old admitted on 6/22/23, with medical diagnosis of opioid use, nicotine dependence, psychoactive substance abuse, acute respiratory failure, poisoning by antineoplastic and immunosuppressive drugs accidental encounter, and chemotherapy. Face sheets, medical diagnosis, physician order sheets, minimum data set [MDS] Brief Interview Mental Status score of 15 indicates R313 is cognitively intact, care plans, medication administration record, treatment administration record, and progress notes. Progress notes indicate in part: -6/23/23 at 3:25 PM -Social Service Note-R313 self-reported of have a 30-year history of drugs heroin and crack. R313 last usage was 2 weeks ago. -7/15/23 at 4:12 PM- Social Service Noted- R313 agrees not to distribute any illegal substances throughout the facility. -7/28/23 at 12:11 PM-Nurse Note- R313 was brought back from chemotherapy and transportation open the door to bring R313 into the facility. R313 would not come into the facility and kept walking down the street. R313 called the facility and stated he will not be returning and will be to pick up personal belongings. Physician notified. On 8/17/23 at 12:54 PM, V13 [Wound Care Coordinator] stated, "On 7/24/23 I was making wound rounds to complete wound care and R125 was not responding. I called his name he still did not response, but he was breathing and had a heart rate. I did a sternum rub, and R125 did not	S9999		

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respond. I ran and called out for R125 nurse, called a rapid response on the overhead paging system, and grabbed the crash cart. V39 [Licensed Practical Nurse] assisted R125 and I went to print off R125 paperwork and held the elevator for 911. When I returned to R125's room, R125 was awake a very upset. R125 said to the nursing staff, why you all give me that medication, I was okay. R125 was yelling and curing at the staff. R125 was transported to the emergency room."

On 8/17/23 at 12:46 PM, V2 [Director of Nursing] stated, "I have been working here at this facility since July 10, 2023, however I been a registered nurse for six years. I was here when R125 over dosed on heroin. I saw 911 pull up in front of the facility. I went up on the unit and R125 was waking up. The nurse told me she administered Narcan to R125 a few times and called 911. At first R125 refused to be transported for emergency room evaluation. R125 became verbally aggressive and yelling. The ambulance drivers were able to convince R125 to go and get evaluated, finally R125 agreed. After R125 left the facility. I found three small plastic bags with a brown powder substance inside the bag in R125's bed. The brown powder substance was underneath R125 buttocks area. The brown powder substance was believed to be heroin. When I phoned the hospital, it was confirmed that R125 has overdosed on heroin. I spoke with the staff and other residents on the third floor. The staff thought R125's family member or roommate gave R125 the heroin. R125's family member brought drugs in the facility before for R125."

On 8/17/23 at 12:58 PM, V38 [Social Services] stated, "At the time of R125's drug overdose, I was the social worker for the third floor. On

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S9999	Continued From page 8 7/15/23 R313 went out on pass and tried to bring in illegal substances. R313 told me that he was brought in cocaine for R125 and other residents in the facility. R313 and I had a rapport, and I asked R313 to be straight up honest with me. R313 told me he got the cocaine from gas station. My intervention was to have R313 sign a behavior contract that he wound not go out and purchase cocaine and bring it back in to the facility for other residents. At that time R313 was not allowed to have visitors or go out on pass for thirty days which will end on August 15, 2023. R125 and R313 was roommates, I did not think changing their room would have resolved or stopped any thing from happening. Also, the third floor is for drug opioid substance abuse floor, which the staff provides frequent monitoring. R125 has been giving multiple behavior contracts, that he did not sign. Which includes R125 multiple offensives for smoking in bed and using drugs." On 8/17/23 at 1:18 PM, V1 [Administrator] stated, "I started working here on the same day R125 was found unresponsive on 7/24/23. I heard staff call a rapid response and I went to the location. I saw staff standing outside R125's room and he was awake. 911 was on the way. R125 was fussing because he did not want to go the hospital. The ambulance drivers convinced R125 to go for an evaluation. During my investigation there was some type of drug usage. V2 [Director of Nursing] received confirmation from the hospital that R125 had a drug overdose. I do not know how R125 got a hold of heroin. R125 could have got drugs from another resident, family member, or visitor from another resident V14 [Director of Social Services] interviewed R125's roommate. The staff on the third floor all said they think it could have been a visitor or another	S9999		

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resident, but no one was certain and had no proof. I want to change the population of this facility geared towards long term care and rehab services; this is not a drug rehab facility."

On 8/15/23 at 10: 13 AM, V2 [Director of Nursing] stated, V39 [Licensed Practical nurse was on vacation, but will work 8/16/23 day shift.

On 8/16/23 at 9:43 AM, V2 stated, "V39 was not on the schedule to work today, I made a mistake."

On 8/16/23 at 10:12 AM, surveyor phoned V39, no answer, unable to leave voice mail.
1:22 PM, no answer, unable to leave voice mail.
2:49 PM, no answer, unable to leave voice mail.

Policy documented in part: Substance Abuse Policy dated 5/23
-The facility reserved the right to protect all residents, staff, and visitors from the negative effects of substance abuse. The facility will take all precautions necessary to prevent residents from using alcohol or illegal substances.

R113's health record documented admission date of 1/12/21 with diagnoses not limited to Paroxysmal atrial fibrillation, Essential hypertension, Type 2 diabetes mellitus, Major depressive disorder, Anxiety disorder, Vitamin D deficiency, Gastro-esophageal reflux disease, Hyperlipidemia, Anemia, Nicotine dependence, Heart failure, Atherosclerotic heart disease.

R413's health record documented admission date of 7/11/23 with diagnoses not limited to Chronic obstructive pulmonary disease, Type 2 diabetes mellitus, Anxiety disorder, Opioid abuse, Cocaine

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abuse, Heart failure, Chronic respiratory failure, Nicotine dependence, Dependence on supplemental oxygen, Major depressive disorder, Essential hypertension, Insomnia, Asthma, Bipolar disorder.

On 8/15/23 at 11:30 am Observed R113 lying in bed, alert and oriented x 4, verbally responsive. R113 stated that he (R113) is smoking at the designated smoking area - outside patio. Observed with a pack of cigarette and lighter by the TV stand at bedside.

At 1:00 pm Observed R413 up and about in room, alert and verbally responsive, with oxygen at 2L/min via nasal cannula. R413 stated that she (R413) is a smoker. Observed a pack of cigarette at bedside table.

On 8/16/23 at 1:44 pm V14 (Social Service Director / SSD) stated she has been working in the facility since 2019. V1 (Administrator) was present during V14's interview.
V14 (SSD) stated that resident who smoke will be evaluated for any unsafe smoking behaviors by completing smoking risk assessment upon admission, quarterly, annually, and as needed. V14 stated that the purpose of smoking assessment is to determine unsafe smoking behaviors and the risk factors for safety of the residents and staff.
V1 (Administrator) stated that smoking policy was ruled out 3 weeks ago, discussed the process and slowly implement it. V1 stated that facility should keep all smoking materials for safety.
Reviewed R113's electronic health record (EHR) with V14 and confirmed that smoking assessment was last completed on 1/27/21.
R113's care plan dated 1/9/23 reviewed with V14 and V1 and confirmed that smoking care plan

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S9999	Continued From page 11 interventions included but not limited to smoking materials should be kept by facility; Assess Consumer's ability to adhere to smoking program per facilities guidelines. V14 confirmed that R413 uses oxygen and is an active smoker. V14 stated that R413 was educated regarding smoking cessation or safe smoking. V14 confirmed that no care plan for smoking found in R413's EHR. MDS (Minimum Data Set) dated 8/3/23 showed that R113's cognition was intact. R113 needed supervision with bed mobility, transfer, walk in room and corridor, locomotion on and off unit, dressing, eating, toilet use and personal hygiene. MDS showed that R113 with current tobacco use. R113's Smoking Risk Assessment dated 1/27/2021 documented in part: Safe smoker. Monitor per facility safe smoking guidelines. Care plan dated 1/9/23 documented in part: R113 makes the choice to continue to smoke. Care plan interventions included but not limited to assess consumer's ability to adhere to smoking program per facilities guidelines. Care plan intervention: Cigarette lighters are to be kept with cigarettes was deleted when facility provided the printout care plan dated 8/17/23. Care plan dated 8/15/23 included interventions not limited to provide R113 with smoking materials during smoke time. MDS (Minimum Data Set) dated 8/3/23 showed that R413's cognition was intact. R413 needed supervision with bed mobility, transfer, walk in room and corridor, locomotion on and off unit, dressing, eating, toilet use and personal hygiene. MDS showed that R413 with current tobacco use.	S9999		

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S9999	Continued From page 12 R413's Smoking Risk Assessment dated 7/13/23 documented in part: safe smoker. Monitor per facility safe smoking guidelines. On 08/15/23 at 3:13 PM, observed pack of cigarettes at R82's bedside. On 08/16/23 at 12:52 PM, observed R118 waiting in hallway outside smoking patio for 1:00 PM smoke break. R118 showed surveyor that R118 was carrying cigarettes by showing surveyor cigarettes in a bag. On 08/15/23 at 1:31 PM, V5 (Psychosocial Aide) stated that the residents right now are allowed to keep their cigarettes and lighters on them in their room. On 08/16/23 at 1:58 PM, V1 stated the policy provided to surveyors is the policy the facility is currently following. R82's diagnosis included but not limited to Malignant Neoplasm of Hypopharynx, Chronic Obstructive Pulmonary Disease, Encounter for Attention To Tracheostomy, Encounter For Attention To Gastrostomy, Solitary Pulmonary Nodule, Cognitive Communication Deficit, Nicotine Dependence Insomnia, Protein Calorie Malnutrition, Dysphasia. R82's Care Plan documents in part smoking preference R82 continues to smoke and interventions include but not limited to keep resident's cigarettes in the medication room or activity closet. R82's MDS (Minimum Data Set) dated 08/01/23 indicates intact cognition, supervision required with bed mobility, transfer, walking, locomotion,	S9999		

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RYZE WEST	5130 WEST JACKSON BOULEVARD CHICAGO, IL 60644

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 13 dressing, personal hygiene, and R82 is a smoker. R118's diagnosis included but not limited to Pulmonary Embolism Without Acute Cor Pulmonale, Abnormalities of Gait And Mobility, Weakness, Lack Of Coordination, Chronic Systolic Congestive Heart Failure, Ascites, Peripheral Vascular Disease, Anemia, Thrombocytosis, Schizophrenia, Schizoaffective Affective Disorder, Malaise, History Of Falling, Symptoms And Signs Involving The Musculoskeletal System. R118's care plan dated 10/13/22 documents in part R118 makes the choice to continue to smoke. R118's Smoking Risk Assessment last completed 10/13/22. R118's MDS (Minimum Data Set) from 06/26/23 indicates intact cognition, extensive assistance required with bed mobility, transfer, locomotion, toilet use, dressing, and personal hygiene, limited range of motion to lower extremities on both sides, uses a wheelchair for mobility and R118 is a smoker. Facility's smoking safety policy dated August 2023 documented in part: - Designated staff members will hold resident's cigarettes and distribute during designated smoking times only. - It is against facility policy to carry a lighter (and other smoking materials i.e. cigarettes, tobacco, etc). Being caught in possession with a lighter and / or cigarettes / smoking materials will be considered a violation of the policy and consequences will be reviewed on an individual	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004832	A. BUILDING _____ B. WING _____	08/18/2023

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S9999	Continued From page 14 basis. - Residents who smoke will be evaluated at admission (within the first 72 hours of admittance), quarterly, and annually, as well as if unsafe smoking behaviors / cognitive decline that affects smoking behaviors occur, to determine their ability to comply with safety rules. (A)	S9999		