| TATEMEN | epartment of Public T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | SURVEY |
|--------------------------|---|--|---------------------------|---|-------------|-------------------------|
| | | | A. BUILDING: | | | |
| | | IL6004832 | B. WING | | 05/2 | 24/2024 |
| IAME OF F | ROVIDER OR SUPPLIER | | DDRESS, CITY, S | | | |
| RYZE WE | ST | | ST JACKSON O, IL 60644 | BOULEVARD | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE | (X5) COMPLET DATE |
| S 000 | Initial Comments | | S 000 | | | |
| | Annual Health Cert | ification Licensure | | | | |
| S9999 | Final Observations | | S9999 | | | |
| | Statement of Licens | sure Violations 1 of 3 | | | | |
| | 300.610a) 300.1210b) 300.1210d)1 300.1210d)2 | | | | | |
| : | Section 300.610 R | esident Care Policies | | | | |
| | procedures governi facility. The written be formulated by a Committee consisti administrator, the a medical advisory co of nursing and othe policies shall comp The written policies the facility and shal | dvisory physician or the ommittee, and representatives r services in the facility. The ly with the Act and this Part. shall be followed in operating I be reviewed at least annually documented by written, signed | | | | |
| | Section 300.1210 (Nursing and Persor | General Requirements for nal Care | | | | |
| | and services to atta practicable physica well-being of the re- each resident's con plan. Adequate and | provide the necessary care in or maintain the highest I, mental, and psychological sident, in accordance with nprehensive resident care I properly supervised nursing care shall be provided to each | | | | |
| | tment_of Public Health ′ DIRECTOR'S OR PROVID | DER/SUPPLIER REPRESENTATIVE'S SI | GNATURE | TITLE | | (X6) DATE |
| | cally Signed | | | | | 06/09/24 |

| STATEMEN | Department of Public NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
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| | | IL6004832 | B. WING | | 05/ | 24/2024 |
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| RYZE WI | EST | | ST JACKSON D, IL 60644 | BOULEVARD | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC' | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| S9999 | Continued From pa | ge 1 | S9999 | | | |
| | resident to meet the care needs of the re | e total nursing and personal esident. | | | | |
| | | | | | | |
| | | uding oral, rectal, hypodermic, ramuscular, shall be properly | | | | |
| | | d procedures shall be lered by the physician. | | | | |
| | These Requiremen evidenced by: | ts were NOT MET as | | | | |
| | reviews the facility f appropriate treatme practical mental and one [R125] resident | ent to attain the highest d psychosocial wells-being of t reviewed in a sample of 35. I in R125 feeling sad, | | | | |
| | Findings include: | | | | | |
| | the medical diagnos hyperactivity disord | ld admitted on 4/27/24, with sis of attention-deficit er, depression, paraplegia, function of bladder, essential | | | | |
| | (Adderall) [Controlle | der dated 5/15/24- e Sulfate Oral Tablet 5 MG ed Drug], give 1 tablet by ng and afternoon for ADHD. | | | | |

| STATEMEN | epartment of Public IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | | E SURVEY PLETED |
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| | | IL6004832 | B. WING | | 05/ | 24/2024 |
| | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE. ZIP CODE | • | - |
| RYZE WI | EST | 5130 WE | ST JACKSON O, IL 60644 | | | |
| (X4) ID | SUMMARY STA | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF | CORRECTION | (X5) |
| PRÉFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | THE APPROPRIATE | COMPLE DATE |
| S9999 | Continued From pa | age 2 | S9999 | | | |
| | Dated 4/28/24- Nur and weights, he be nurse practitioner (2 4/28/24-Nurse note increase in anxiety 4/29/24-Nurse note 5/2/24-nurse practi back on ADHD me ordered. 5/2/24- social servi moderate severe d 5/3/24-nurse note and lab work. 5/5/24- nurse note: 5/6/24- nurse note: 5/6/24- nurse note: 5/12/24, 5/13/24 nu 5/14/24- nurse note 5/15/24- nurse note 5/15/24 thru 5/23/2 [V47]. 5/20/24 nurse note 5/23/24 nurse note | e: refused ADL care. tioner note requested to go ds, and psychiatry consult ce note: R125 presents with epression. refused ADL care. refused ADL care, shower, picking wounds. attempted to throw away s. picking wounds. urse note: refused ADL care. e: R125 request to psychiatrist e: [V2 Director of Nursing] sed R125 and prescribed new etamine Sulfate Oral Tablet 5 ntrolled Drug], give 1 tablet by ng and afternoon for ADHD. Next visit with psychiatrist in 4- No note from psychiatrist : refused skin treatment. : refused ADL care. at 13:51 (1:51PM) phoned scription for ne Sulfate Oral Tablet 5 MG | | | | |
| | | Administration Sheet: phetamine Sulfate Oral Tablet | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (X3) DATE SURVEY COMPLETED | |
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| | | | A. BUILDING. | | | | |
| | | IL6004832 | B. WING | | 05/ | 24/2024 | |
| IAME OF F | PROVIDER OR SUPPLIER | STREET AI | DDRESS, CITY, ST | TATE, ZIP CODE | | | |
| RYZE WI | EST | | ST JACKSON O, IL 60644 | BOULEVARD | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | FION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE | |
| S9999 | Continued From pa | ige 3 | S9999 | | | | |
| | by mouth in the mo | ontrolled Drug], give 1 tablet prning and afternoon for ADHD ot administered 5/15/24 thru | | | | | |
| | admitted here on 4, psychiatrist, but I w psychiatrist [V47] o medication, Dextro- been taking since I 5/16/24, I did not re asking different nur the Dextroampheta told me they will ca they was going to o nurses called V47. made me feel territ tired, disorganized, | 7 AM, R125 stated, "I was /27/24. I requested to see a ras not seen until 5/15/24. The n 5/15/23, reorders my amphetamine Sulfate that I was sixteen years old. On eceive my mediation. I been rses, why I have not received mine Sulfate. Some nurses II pharmacy, other nurses said call V47. I don't think the Not having my medication has ole, feeling sad, depressed, and not wanting to move L care. I just been staying in ng to be bothered." | | | | | |
| | V47 [Psychiatrist] s the first time on 5/1 needed the medica Sulfate Oral Tablet a teenager. After m determined that R1 medication to treat disorder [ADHD]. I [Director of Nursing to pharmacy. The s allow any of my ord and delivered, and with the pharmacy. notification from nu | PM, (Face to Face Interview) tated, "I assessed R125 for 5/24. R125 expressed he tion Dextroamphetamine 5 MG, that he has taken since by assessment it was 25 did in fact need the attention-deficit hyperactivity completed a form with V2 g] and she was to fax the form sign form to pharmacy will lers for narcotics to be filled my signature will remain of file I did not receive any rsing staff that R125 did not tion. I was not made aware the | | | | | |

| STATEMEN | Department of Public NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: _ | CONSTRUCTION | | E SURVEY PLETED |
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| | | IL6004832 | B. WING | | 05/ | 24/2024 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AI | DDRESS, CITY, S | TATE, ZIP CODE | | |
| RYZE WI | EST | | ST JACKSON D, IL 60644 | BOULEVARD | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ¹ | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| S9999 | Continued From pa | ge 4 | S9999 | | | |
| | mood, tired, and po to R125's room and behavior. I will com submit them to pha medication today. I psychological asses document my enco encounter today for On 5/22/24 at 3:10 stated, "I placed in | PM, V2 [Director of Nursing] the order for R125's | | | | |
| | Tablet 5 MG. I rece 5/15/24. V47 was s prescription and fax in the progress note thought V47 complet the order over to ph aware that R125 did from pharmacy. The order, a prescription faxed to pharmacy. delivered, the nursi pharmacy to find our resident's medication | Imphetamine Sulfate Oral ived the order from V47 on upposed to complete a (it to the pharmacy. I did place e in R125's clinical record. I eted the prescription and faxed harmacy. I was not made d not receive his medication e procedure for any narcotic n must be completed and If the medication was not ng staff should first call ut the reason why the on was not delivered. Then cal | 1 | | | |
| | If a resident does n Dextroamphetamin potentially can cont | y need prescriptions or forms. ot receive e Sulfate, the behaviors inue or worsen. V47 should ssments and encounter with | | | | |
| | receive my Dextroa Tablet 5 MG, today The first and last tir My nurse V8 [Licen | 5PM, R125 stated, "I did not mphetamine Sulfate Oral I did not see V47 yesterday. ne I saw him was on 5/15/24. sed Practical Nurse] told me s faxed yesterday (5/22/24). | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | E SURVEY PLETED |
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| | | IL6004832 | B. WING | | 05/ | 24/2024 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | |
| RYZE WI | EST | | ST JACKSON O, IL 60644 | BOULEVARD | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLETI DATE |
| S9999 | Continued From pa | ge 5 | S9999 | | | |
| | Nurse) stated, "V47 faxed R125's media On 5/23/24 at 1:00 stated, "I will call the prescription was fax V17 phoned the phe presents of V8 and said there was no p transferred to the d verified there was no | 7 PM V8 (Licence Practical 7 told me yesterday that he cation to the pharmacy." PM, V17[Wound Care Nurse] e pharmacy to find out if the xed." armacy on speaker in the surveyor. The pharmacist prescription on file. V17 was ata entry department, it was to fax, e-script, sent to the . V8 stated, "I will call V47 for | | | | |
| | -A controlled substational dispensed by the planet of the planet state of the planet s | ce Orders (No Date) ance medication will be harmacy if all state and federa net. ance prescription will only be ensed if the pharmacy receives substance prescription can be armacy by the following ways. | | | | |
| | (B) | | | | | |
| | Licensure Violatior | ns 2 of 3 | | | | |
| | 300.615e) | | | | | |
| | | etermination of Need uest for Resident Criminal rmation | | | | |

STATE FORM

| STATEMEN | Department of Public NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
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| | | IL6004832 | B. WING | | 05/ | 24/2024 |
| NAME OF | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| RYZE W | EST | | ST JACKSON O, IL 60644 | BOULEVARD | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC | FION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE |
| S9999 | Continued From pa | ge 6 | S9999 | | | |
| | Section 2-201.5(a) facility shall, within resident, request a check pursuant to t Information Act for seeking admission background check pursuant to the Hos Background checks resident's name, da identifiers as requir Police. (Section 2-2 Based on interview failed to check and Criminal History Inf (CHIRP), Illinois Se Illinois Department of admission for 9 (R145, R153, R71, F reviewed for Identif failure resulted in R R145, R153, R71, a background check Offender Program f | s shall be based on the ate of birth, and other ed by the Department of State 201.5(b) of the Act) , and record review the facility review the results of the ormation Response Process x Offender Registry, and of Corrections within 24 hours R162, R57, R140, R51, R48, R170) out of 10 residents ied Offender Protocol. This 162, R57, R140, R51, R48, and R170 not having a submitted to the Identified | | | | |
| | Findings Include: | | | | | |
| | checks were review 1. R162 was adm CHIRP was comple Sex Offender Regis | cal records and background ved and revealed the following itted on 1/11/24. R162's oted on 3/20/24. R162's Illinois stry (ISOR) and Illinois ections (IDOC) were 24. | | | | |
| | | ted on 6/30/21. R57's CHIRP 5/07/24. R57's ISOR, and ted on 5/22/24. | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | IL6004832 | B. WING | | 05/ | 24/2024 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, ST | ATE, ZIP CODE | | |
| RYZE WI | EST | | ST JACKSON D, IL 60644 | BOULEVARD | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE |
| S9999 | CHIRP was completed on 1/26/ 4. R51 was admitt was completed on 2/26/ 1DOC were completed on 3/26/ 5. R48 was admitt was completed on 4/26/ 1DOC were completed on 4/27 1DOC were completed on 4/27 2000 was completed on 4/27 2000 was completed on 4/27 2000 was completed on 4/27 2000 were completed on 4/27 2000 | itted on 1/27/23. R140's ated on 2/14/23. R140's ISOR 1/25/23 and IDOC was 23. ted on 5/22/19. R51's CHIRP 5/29/19. R51's ISOR and ted on 5/28/19. ted on 10/20/17. R48's CHIRP 8/31/23. R48's ISOR and ted on 10/23/17. ted on 2/17/17. R71's CHIRP 4/28/17. R71's ISOR and ted on 2/17/17. itted on 4/17/24. R145's ated on 4/29/24. R145's ISOR mpleted on 4/29/14. itted on 10/20/23. R153's ated on 11/03/23. R153's ated on 5/22/24. itted on 3/4/24. R170's CHIRP 3/6/24. 4 AM, interviewed V16 (Social nd stated that ISOR, NSOR und checks are usually done ore the residents get admitted atated that CHIRP should be sident's admission in the always done within 24 hours of | | | | |

| STATEMEN | epartment of Public IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
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| S9999 | Continued From pa | ge 8 | S9999 | | | |
| | (C) | | | | | |
| | Licensure Violation | s 3 of 3 | | | | |
| | Section 300.625 Id | entified Offenders | | | | |
| | history background is an identified offer | s of a resident's criminal check reveal that the resident nder as defined in Section the facility shall do the | | | | |
| | fingerprint-based cr be requested on the The inquiry shall be sex, race, date of b other identifiers req State Police. The in through the files of Police and the Fede locate any criminal may exist regarding Bureau of Investiga Department of State inquiry under this su | ours, arrange for a iminal history record inquiry to e identified offender resident. based on the subject's name irth, fingerprint images, and uired by the Department of nquiry shall be processed the Department of State eral Bureau of Investigation to history record information that g the subject. The Federal ition shall furnish to the e Police, pursuant to an ubsection (c)(2), any criminal mation contained in its files. | , | | | |
| | failed to order finge History Information or registry backgrou HIT for qualifying of R71, R153) out of 1 Identified Offender in R162, R57, R140 | , and record review the facility rprints if any of the Criminal Response Process (CHIRP) und results come back with a ffense for 5 (R162, R57, R140 I0 residents reviewed for Protocol. This failure resulted D, R71, R153 not having a submitted to the Identified timely. | | | | |

| | epartment of Public | | | | | |
|---------------|---|--|-------------------------------|---|----------------|--------------------|
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| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF C | ORRECTION | (X5) |
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| S9999 | Continued From pa | ige 9 | S9999 | | | |
| | Findings Include: | | | | | |
| | checks were review 1. R162's CHIRP back with a "HIT". F on 4/22/24. 2. R57's CHIRP d with a "HIT". R57's 5/14/24. 3. R140's CHIRP back with a "HIT". F on 2/20/23. 4. R71's CHIRP d with a "HIT". R71's 5. R153's CHIRP | cal records and background ved and revealed the following: dated 3/20/24 result came R162's fingerprint was ordered lated 5/7/24 result came back fingerprint was ordered on dated 2/14/23 result came R140's fingerprint was ordered lated 4/28/17 result came back fingerprint ordered on 5/4/17. dated 11/03/23 result came R153's fingerprint was ordered | | | | |
| | Service Director) ar background checks like certain offenses would say hit or mu automatically scheo hours. We get the s from the fingerprint in the facility. Then | dule the fingerprint within 72 sign release and the individual will stamp. They usually come after that we email the CHIRP orm and another form to the Program." | | | | |
| | BACKGROUND IN documents in part: admission to the fa- hours. Within 48 ho as a "HIT" and is de hit, then the resider consent form and b | STRUCTIONAL" with no date When you have a brand-new cility run CHIRP within 24 burs if the CHIRP comes back etermined to have qualifying in thas to sign the fingerprint be fingerprinted only if there is a that was committed. Within | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X3) DATE SU COMPLET | |
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| | | IL6004832 | B. WING | | 05/2 | 24/2024 |
| IAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | |
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| S9999 | Continued From pa | ge 10 | S9999 | | | |
| | 72 hours set up a ti to come in to the fa the resident. | me for the fingerprint vendor cility to take the fingerprints of | | | | |
| | (C) | | | | | |
| | | | | | | |
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