

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058651		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2025
NAME OF PROVIDER OR SUPPLIER RYZE AT THE RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6450 NORTH RIDGE BLVD , CHICAGO, Illinois, 60626			
(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) COMPLETION DATE
S0000	Initial Comments Investigation of Facility Reported Incident of 5/2/25/IL192147	S0000			
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	S9999			

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued from page 1</p> <p>comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>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:</p> <p>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.</p> <p>These requirements were not met as evidenced by:</p> <p>Based upon observation, interview, and record review, the facility failed to immediately assess a resident (post fall), failed to follow physician's orders, and failed to provide timely hospital transfer for one of three residents (R3) reviewed for falls. These failures resulted in R3's (5/2/25) delayed care of a fall with right impacted intertrochanteric fracture - with varus deformity [an excessive inward angulation of a joint or bone's distal segment] which required surgical intervention and likely experienced excruciating pain [for roughly 33 hours - prior to transfer] which was rated 3/10 - by facility staff.</p> <p>Findings include:</p> <p>R3's diagnoses include metabolic encephalopathy and fracture of unspecified part of neck of right femur.</p> <p>R3's (5/14/25) BIMS (Brief Interview Mental Status) determined a score of 6 (severe cognitive impairment).</p> <p>R3's (5/14/25) functional assessment affirms resident is dependent on staff for chair/bed to chair transfer</p>	S9999			

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S9999	<p>Continued from page 2 and walking was not attempted due to medical condition or safety concerns.</p> <p>R3'S (10/2/24) fall risk evaluation determined a score of 25 (high risk).</p> <p>R3's progress notes states (5/2/25) at approximately 10:00 am, resident observed with an unwitnessed fall in his room. Noted to be lying in supine position on the floor by his bed with rolling walker next to him. Unable to narrate events leading to the fall. Observed with facial grimacing during passive range of motion to right leg. Medical Doctor notified with orders for x-ray of bilateral hip and knee to rule out injury. Order noted and carried out. Acetaminophen administered for pain. Urgent care called for x-rays; all papers faxed. 3:25 pm, urgent care here to carry out x-ray [roughly 5.5 hours after fall] to bilateral hips ["knee" x-ray was excluded] awaiting results. (5/3/25) 1:12pm, Resident observed hopping on right leg, X-ray carried out per doctor order; results show right hip fracture [roughly 22 hours after x-rays were obtained]. Doctor gave order to transfer resident to nearest ER (Emergency Room). 7:18 pm, Order to transfer resident to ER carried out [roughly 6 hours after transfer orders were received and 33 hours after R3 fell].</p> <p>R3's (5/2/25) Physician Order Sheets include x-rays of bilateral hip - entered at 10:33am [x-ray of "knee" is excluded].</p> <p>R3's (5/2/25) right hip x-ray affirms impacted intertrochanteric fracture with varus deformity - reported 5/2/25 at 10:04pm [roughly 12 hours after x-ray orders were received].</p> <p>R3's (5/3/25) Medication Administration Record states that pain was rated 3/10 on evening shift.</p> <p>On 5/28/25 at 10:21 am, V2 (Director of Nursing) stated "He (R3) had a fall on 5/2 around 10:00 in the morning. At the time of the fall there were no signs of injury or apparent injuries noted. R3 exhibited facial grimacing during range of motion per 5/2 progress note]. He started showing injury the following day, so the doctor sent him out for evaluation."</p>	S9999			

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S9999	<p>Continued from page 3</p> <p>On 6/2/25 at 11:53 am, V7 (Licensed Practical Nurse) stated "On 5/2/25, I saw him (R3) on the floor because it was unwitnessed fall. The resident (R3) can't talk much, he don't (sic) remember exactly what happened. After the assessment was done, he can't verbalize pain but he was grimacing when we were doing the range of motion on the right leg. I notified the doctor and he ordered for x-ray that we should do bilateral x-ray to the legs it was carried out, done. I called the state guardian and give (sic) a pain pill. R3's (5/2/25) X-ray order wasn't put in stat because when I called the doctor, he didn't say to put stat, so I didn't get a stat order from the doctor. I don't remember if the physician ordered "x-ray of bilateral hip and knee to rule out injury" per progress note (entered by V7), but I know its bilateral leg. I know when I was documenting I wanted to put knee and leg."</p> <p>R3's (5/4/25) history & physical includes Musculoskeletal: Deformity present, right lower extremity externally rotated.</p> <p>R3's (5/6/25) history and physical affirms status-post right hip intramedullary nailing.</p> <p>On 5/29/25 at 1:55pm, V11 (Medical Director) stated "When a resident falls, they (staff) usually assess the patient, call me (V11) right away, and let me know what's going on. The resident should be assessed as soon as the patient fell, they have to assess right away." Surveyor inquired if a resident sustains an unwitnessed fall and exhibits facial grimacing during passive range of motion (to the right lower extremity) what should be ordered V11 replied "We order the x-rays if there's swelling of the knee or hip we order the x-rays right away. If the patient is confused, we send the patient out" [R3's cognitive status is severely impaired]. V11 stated that x-rays (post fall) should be ordered stat and once the x-ray is done staff should be following up with the provider or the provider should be calling the facility with results and that the provider usually calls within 1 or 2 hours for the results. V11 also stated that resident should be transferred to the hospital if they see any deformity. V11 further explained that a lower extremity varus deformity presents usually the leg is rotated to the left if it was the right leg and that the potential harm to a resident that sustained an unwitnessed fall is that "If there's fracture, there is pain and sometimes surgery is required."</p>	S9999			

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S9999	<p>Continued from page 4</p> <p>Considering reasonable person concept, right lower extremity deformity, and fracture (which required surgery) R3's pain was likely excruciating therefore higher than 3/10.</p> <p>On 5/27/25 at 2:12pm, R3 was observed lying on the floor (adjacent the bed) and the curtain was pulled. V6 (Certified Nursing Assistant) affirmed that she was assigned to R3 at the time of R3's fall incident. V6 stated "I was here (room) watching him and went to bring water for him, and the Nurse saw he was sliding down." R3 was unable to provide a description of what happened due to cognitive status. Several staff subsequently entered the room and transferred R3 back to bed [prior to assessment].</p> <p>On 5/27/25 at 2:22 pm, V7 (Licensed Practical Nurse) entered R3's room and affirmed that she was assigned to R3 at the time of R3's fall. V7 stated "He (R3) went for therapy, he just came in. I'm the one that set him down. I saw him from the Nurse's station trying to slide down." Surveyor inquired if R3's vital signs were obtained post fall V7 responded "I want to do it now, I'm doing it. I'm gonna assess the patient and call the doctor" [roughly 10 minutes after falling]. V7 also stated " If a resident falls, the nurse should assess the resident before we (staff) pick them up. I did not assess R3 prior to placing back in bed because I went downstairs to get the (mechanical lift). No, that getting the mechanical lift is not the priority."</p> <p>On 5/28/25 at 10:36 am, V2 (Director of Nursing) stated "When a resident falls, we (Nurses) assess the patient before transferring. We do vital signs, range of motion and assess for injuries before we move this patient."</p> <p>The change in resident condition policy (reviewed 01/2025) states Nursing will notify the resident's physician or nurse practitioner when: there is a significant change in the resident's physical, mental or emotional status. It is deemed necessary or appropriate in the best interest of the resident.</p> <p>"A"</p>	S9999			