STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058040	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RYZE WEST	5130 WEST JACKSON BOULEVARD , CHICAGO, Illinois, 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) COMPLETION DATE
S0000	Initial Comments COMPLAINT INVESTIGATION: 2584147/IL00192196 - F880 2584236/IL00192290 - 300.690 2583769/IL00191212 - No deficiency	S0000		
S9999	Final Observations Statement of Licensure Violations: Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each	S9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 reportable accident or incident to the Department within seven days after the occurrence. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to timely report a resident's fall with serious injury to the State agency for one resident (R6) with a left femur fracture reviewed for resident injury in the sample of 5 residents (R2, R3, R4, R6 and R7). Findings include: R6's Admission Record documents, in part, diagnoses of paraplegia, fracture of left femur, chronic osteomyelitis, end stage renal disease, kidney transplant status, sepsis, peripheral vascular disease, hypertension, hyperlipidemia, major depressive disorder, hypotension, anemia, personal history of COVID-19, anxiety disorder, injury at T7-T10 level of thoracic spinal cord, flaccid neuropathic bladder, and peritoneal abscess. R6's Minimum Data Set (MDS), dated 4/7/25, documents, in part, a Brief Interview for Mental Status (BIMS) score of 15 which indicates that R6 is cognitively intact. R6's Functional Abilities for Functional Limitation in Range of Motion indicate impairment on both sides of R6's lower extremities and that R6 utilizes a wheelchair as a mobility device. On 5/20/25 at 5:10 PM, V13 (Licensed Practical Nurse, LPN) stated that V13 was R6's primary nurse for the night shift of 4/13/25 to 4/14/25. V13 stated that R6 is alert and oriented times 4, is a mechanical lift for transfer, and has a motorized wheelchair. V13 stated that during rounds, V13 observed R6 sitting on floor on buttocks with legs out in front of R6, next to R6's bed. V13 observed R6 as alert, was talking, and saying that R6 attempted to self transfer from the bed to the wheelchair. V13 stated that V13 performed a head to toe assessment and that R6 denied hitting head, denied pain, and no leg length discrepancy, redness or swelling was noted. R6 kept saying that R6 was more embarrassed from the fall and knows that R6 should have called for help. V13 stated that V13 and V14 (Certified Nursing Assistant, CNA) used the mechanical lift machine and transferred R6 from the floor back to the	S9999		

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S9999	Continued from page 2 bed. V13 stated that V13 notified the emergency contact, R6's physician, and V2 (Director of Nursing, DON). On 5/21/25 at 10:10 am, V9 (Registered Nurse, RN/Assistant Director of Nursing, ADON) stated that on 4/14/25 during day shift, V9 was rounding on the floor and spoke to R3 and noted R3's left leg swelling. V9 stated that V9 notified V19 (Nurse Practitioner) and an order for X-rays was obtained. V9 stated that R3 was transferred to the hospital on 4/14/25 for further evaluation. V9 stated that on 4/15/25, V9 had phone call with a hospital nurse about R3's condition and was informed by the hospital nurse that R3 was offered surgery but is declining the surgery. When asked about why R3 was being offered surgery in the hospital, V9 stated that the hospital nurse "wasn't forthcoming" with further information, and that since R3 is alert and oriented, R3 is decisional about a surgery option. V9 stated that V9 notified V2 (DON) of V9's phone call with the hospital nurse, and V2 and V9 were "figuring out what was going on" with R3's leg. V9 stated that when the hospital records were "uploaded into the system (facility's electronic health record {EHR} system)," this is when V9 viewed R3's "official results" of a left leg fracture. In R6's Progress Notes, V9 (RN, ADON) documents, in part, on 4/14/25 at 3:37 PM, "Note: Resident noted with swelling to (R6's) left leg, upon assessment confirmed the swelling, x-ray ordered." In R6's Progress Notes, V9 documents, in part, on 4/15/25 at 2:42 PM, "Note: Spoke with (hospital nurse), (R6) at this time was offered surgery but declined. Awaiting further follow up, oncoming shift to follow up." Facility document titled "Radiology Results Report" documents, in part, R6's left femur X-ray (minimum 2 views) done on 4/14/25 in the facility has findings of "Examination reveals oblique fracture of the distal shaft of the left femur with lateral displacement of the distal fracture fragment and overriding of the fracture fragments" with impression of "displaced fracture of the distal femur." R6's left femur X-ray was electronically signed by V21 (Radiologist) on 4/14/25 at 4:54 PM. R6's "Radiology Results Report" also shows an X-ray (2 views) for left tibia and fibula with impression of "fractures of the proximal tibia and	S9999		

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S9999	Continued from page 3 fibula and old fracture deformities of the distal tibia and fibula" signed by V21 on 4/14/25 at 4:59 PM. On 5/21/25 at 3:39 PM, V2 (Director of Nursing, DON) stated that V2 is responsible for reporting resident serious injuries to the State agency. V2 stated that V2 must report to the State agency for a fall with serious injury within 24 hours of the fall incident and the final conclusion in 7 days. V2 stated that V2 was notified of R3's fall incident on 4/14/25 by V13 (LPN) with nursing assessment as unremarkable (no leg pain or swelling). V2 stated that a few hours later, R6 complained of leg swelling and X-rays were completed in the facility, then R6 was transferred to the hospital on 4/14/25. V2 stated that on 4/15/25, V2 conferred with V9 about hospital nurse calling about R3 declining surgery, and V2 tried to call back the hospital several times to find out more information but was unsuccessful. V2 stated that on 4/17/25, V2 received R6's hospital records, and "that's when I (V2) reported it (to the State agency), once I had a confirmation of an actual fracture." When asked about reviewing the 4/14/25 in-house facility X-rays for R6, V2 stated that V2 reviewed the X-rays on either 4/14/25 or 4/15/25 and saw that R6's fracture (tibia/fibula) was an old fracture. V2 stated that V2 "wanted to be sure" if R6 had an acute fracture for reporting to the State agency and wanted confirmation from the hospital. Facility document titled "State Report of Patient Incident" and marked as "Preliminary," documents, in part, a "fall with serious injury" for R6 with incident description as "On 4/17/25, received a hospital update that resident (R6) was admitted with Acute Femur fracture. On 4/14/25, (R6) complained of swelling to (R6's) left leg, when asked what happened, (R6) stated that (R6) fell while transferring from bed to (R6's) wheelchair." Date and time of incident are listed as 4/14/25 at 6:45 am. Facility document for email submission to the State agency documents, in part, that R6's preliminary report for fall with injury was submitted to the State agency on 4/17/25 at 8:59 PM via V2's (DON) email address. This is 3 days after R6's fall incident on 4/14/25. Facility document titled "State Report of Patient Incident" and marked as "Preliminary," documents, in part, a "fall with serious injury" for R6 with incident description as "On 4/17/25, received a hospital update	S9999		

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S9999	Continued from page 4 that resident (R6) was admitted with Acute Femur fracture. On 4/14/25, (R6) complained of swelling to (R6's) left leg, when asked what happened, (R6) stated that (R6) fell while transferring from bed to (R6's) wheelchair." Date and time of incident are listed as 4/14/25 at 6:45 am. Facility document titled "State Report of Patient Incident" and marked as "Final," documents, in part, a "fall with serious injury" for R6 on 4/14/25 at 6:45 am with the summary of investigation concluding that R6's "medical records from (hospital) confirmed a new L (left) distal femur fracture and CTA LLE (Computerized Tomography Angiography Left Lower Extremity)." Facility document for email submission to the State agency documents, in part, that R6's final report for fall with injury was submitted to the State agency on 4/23/25 at 10:56 AM via V2's email address. This is 8 days after R6's fall incident on 4/14/25. Facility policy titled "Fall Prevention and Management" dated January 2023 (review date of February 2025) documents, in part, "General: this facility is committed to maximizing each resident's physical, mental and psychosocial well-being. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible. All resident falls shall be reviewed, and the resident's existing plan of care shall be evaluated and modified as needed. Responsible Party: RN, LPN, DON. Guidelines: ... Facility Guideline following a fall incident: ... 6. All incidents and accidents with serious physical injury will be reported to IDPH (Illinois Department of Public Health) within 24 hours. A full written investigative report is required by IDPH within seven (7) days of the incident." (C)	S9999		