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 _____	C 05/18/2023

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

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S 000	Initial Comments Complaint Investigation: 2383300/IL158990 & FRI of 4/17/2023/IL159457	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.3240a) 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	S9999	Attachment A Statement of Licensure Violations	

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care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These Requirements were not met as evidenced by:

Based on interview and record review, the facility failed to ensure that a resident was free from physical abuse which affected one (R1) of three residents reviewed (R1, R2, R4) reviewed for physical abuse. This deficient practice resulted in R1 experiencing new left shoulder pain and limited range of motion which required R1 to be transferred to the hospital with left shoulder musculoskeletal strain.

Findings include:

R1's Admission Record documents, in part, diagnoses of dementia, muscle weakness, bilateral hearing loss, dysphagia, cachexia, and severe protein calorie malnutrition.

R1's Minimum Data Set (MDS), dated 4/17/23, documents, in part, a Brief Interview of Mental Status (BIMS) score of 11 which indicates that R1 has moderate cognitive impairment.

On 5/16/23 at 10:34 am, when asked about the physical altercation with V4 (Former Staffing Coordinator) on 4/17/23, R1 stated, "I (R1) was just there in the hallway." R1 stated, "Why (V4) put (V4's) hands on me, I (R1) don't know. I (R1)

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wasn't doing nothing." R1 stated that V4 said, "Go to your room." R1 stated that R1 was in the hallway, and then "(V4) grabbed (R1's) my left arm to make me (R1) go." R1 then demonstrated on R1's arm where V4 grabbed R1 directly above R1's left wrist. R1 stated, "(V4) grabbed my arm and pulled me. I (R1) pulled my arm back." When asked where this incident took place with V4, R1 stated it was by nurse's station while R1 was standing there. R1 stated that that R1 then fell in the hallway. When asked if R1 told any other staff member in the facility about this incident with V4, R1 stated, "No because that nurse (V7, Licensed Practical Nurse, LPN) didn't do nothing." R1 stated that R1 saw V5 (Certified Nursing Assistant, CNA) and V7 at the nurse's station when it happened. R1 stated that it was around 9:00 to 10:00 pm that night (4/17/23). R1 stated that R1 did not have pain directly after the physical altercation with V4. R1 stated that R1 started to feel pain in R1's left shoulder the "next day or two," and "it (left shoulder) was hard to move." R1 stated, "It was bad enough for me (R1) to know that something was wrong when I (R1) would try to move my (left) arm, pain would shoot down from my shoulder." R1 stated that R1 told V17 (Social Services Director, SSD) about R1's left shoulder pain and limited range of motion. R1 stated that R1 was then transferred to the hospital for pain and not being able to "move it (left shoulder) only at a certain angle."

R1's ambulance transportation record, dated 4/20/23, documents, in part, "(Ambulance) dispatched to (facility) for an Emergency Transport of (R1) to (hospital) for left shoulder pain ... Crew initiates assessment, finds (R1) with pain in (R1's) upper left shoulder ... Crew inquires about (R1's) fall, (R1) notes that 2 days ago, a staff member tried to force (R1) into

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bedroom ... (R1) notes that as of today, (R1) cannot raise left arm above (R1's) head ... inspects and palpates shoulder and notes tenderness upon asking (R1), as well as a small bruise the size of a quarter."

In R1's hospital records, V20 (Hospital Emergency Physician) documents, in part, R1 presenting the hospital emergency department for "left should pain after witnessed fall 3 days ago after a staff member at (facility) pulled (R1) causing (R1) to fall and hit left shoulder." V20 documents, in part, that R1 has "limited ROM with left shoulder abduction" with a differential diagnosis of musculoskeletal strain.

R1's hospital emergency "Discharge Instructions," dated 4/20/23, documents, in part, "Diagnoses from today's visit: Left shoulder pain, Shoulder injury, Elder abuse."

On 5/16/23 at 2:59 pm, V4 (Former Staffing Coordinator) stated that V4 no longer works at the facility and had been "hired as staffing coordinator" with responsibilities of ensuring that the facility has sufficient nursing staffing. V4 stated that V4 is not a nurse or certified nursing assistant (CNA). V4 stated that on 4/17/23, during the evening shift, V4 was in the facility on the 4th floor at the nurse's station trying to get staff to pick up shifts to work, and R1 made sexual comments towards V5 (CNA). V4 stated that V5 (CNA) said to R1, "Go to your room. You all heard (R1) right." V4 stated that V4, V5 (CNA) and V7 (Licensed Practical Nurse, LPN) were at the nurse's station at this time. V4 stated that V4 instructed R1 to go to R1's room. V4 stated, "I said, (R1), go to your room." V4 stated, "(R1) said (R1's) not going nowhere." V4 stated that V4 then walked from behind the nurse's station, and

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R1 was walking to dining room. V4 stated, "I (V4) said, 'You (R1) can't go in there.'" V4 explained that the dining room door was closed, and the dining room is on one side of the nurse's station. V4 stated that V4 put V4's hand on the dining room's doorknob, and "I (V4) put my hands out to block the doorway." V4 said, "I redirect (R1) with other hand. (R1) is pushing my hand down" with R1 saying, "I am not going nowhere." V4 stated that R1 was "trying to move me (V4)." V4 stated "I (V4) pointed to direct (R1)" then R1 pushed V4's pointer arm down. V4 said, "Let's move. Go to your room." V4 stated, "From there, we (R1 and V4) became physical, more of me (V4) placing my hand on (R1's) back or on (R1's) arm, not grabbing. (R1) was shrugging me (V4) off. When this surveyor asked V4 if it's either R1's arm or back, V4 stated, "It was (R1's) arm. Back of arm. I (V4) had it (R1's arm)." V4 stated that at this time, R1 and V4 were in front of the elevators in front of the nurse's station. When asked if R1 is moving voluntarily when V4 had R1's arm, V4 stated, "No, I (V4) was guiding (R1). I (V4) would stop, and (R1) will then stop and start talking." V4 stated that V4 is moving R1 "a little past nurse's station, headed towards (R1's) room and (R1) tried to turn back. I (V4) was right there." V4 stated, "I (V4) was behind (R1). (R1) slid to floor." V4 confirmed with this surveyor that V4 hand wrote a statement and was interviewed by V3 (Former Administrator) on 4/21/23 about this incident with R1.

Facility transcript of V4's interview, dated 4/21/23, titled "(V4), Staffing Coordinator)," and signed by V4, documents, in part, "After I (V4) told (R1) to go to (R1's room), (R1) said no and wen (went) towards the dayroom. I (V4) got up closed the door and blocked the door with my body. I (V4) continue to tell (R1) go to (R1's) room and (R1)

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refused to so I (V4) started to redirect (R1) with my body and then from there I (V4) had my hand up and (R1) grabbed me (V4) to move me (V4) out of the way, so after that I (V4) grabbed (R1's) arm and started moving (R1) towards (R1's) room. (R1) was struggling and slid to the floor."

On 5/17/23 at 3:03 pm, V3 (Former Administrator) stated that on 4/20/23, V3 was the administrator and abuse coordinator of the facility. V3 stated, on 4/20/23, R1's physical abuse allegation was reported to V3 by V17 (Social Services Director, SSD) after their "morning meeting around 10 am." V3 stated, V3 brought R1 into V3's office, and R1 said, "I (R1) was roughed up." V3 stated, V2 (Director of Nursing, DON) and V15 (Assistant DON, ADON) then come into the office with R1. V3 stated, R1 said R1 was roughed up by "man worker." V3 stated, R1 complained of R1's left arm hurting and couldn't lift R1's arm higher than R1's shoulder level while V2 and V15 were assessing R1. V3 stated, V2 and V3 were viewing the video coverage of the 4th floor nurse's station camera (which is above room 417) after identifying V4 (Former Staffing Coordinator) as the alleged abuser towards R1. V3 stated, V2 and V3 could see and hear the incident with R1 and V4 on 4/17/23 on the camera surveillance. This surveyor then asked V3 what V3 saw and heard while viewing this video coverage. V3 stated, it showed at 10:00 pm on 4/17/23 as follows: "V6 was out of camera's view. V4 comes up to R1. R1 had come and leaned on the corner of the nurse's station. Then R1 backed up. V7 was sitting over here at nurse's station by room 401. V5 was standing next to V4 behind the nurse's station on other side by 417. V4 comes over and around the nurse's station. R1 comes out from the dining room. V3 can hear V4 say, '(R1), it's time to go to bed.' R1 said, 'I (R1) told

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you I am not going to bed.' R1 walks around trying to go to the dining room. R1 puts R1's hands up, and V4 grabs R1's arm and pulled R1's arm. V4 was grabbing R1's left arm. R1's right arm was flaying. The dining lights were off. (V4) treated R1 like R1 don't have rights. Enough people are there (and they) didn't stop it. R1 and V4 tussled. V5 moves out the way, and they (R1 and V4) are continuing with V4 pushing and R1 pulling. At end of nurse's station, they turned in the hallway with V4 and R1. And then (R1) breaks free and slides down wall." V3 stated that V3 performed a thorough abuse investigation of R1's physical abuse allegation. When asked if V3's investigation for R1's physical abuse allegation towards V4 was substantiated, V3 stated, "It was."

On 5/17/23 at 12:19 pm, V16 (Nurse Practitioner, NP) stated, V16 is assigned to R1, who has a diagnosis of dementia, and sees R1 monthly in the facility. V16 stated, V16 is in the facility daily from Monday through Friday and will check in with residents for updates. V16 stated, on 4/20/23, V16 received a phone call from a facility staff member about R1's complaint of left shoulder pain. V16 stated, V16 returned to the facility in the afternoon on 4/20/23 and assessed R1 in-person. V16 stated, V3 (Former Administrator) had made V16 aware of R1's physical abuse allegation towards V4. V16 stated, "(R1) was not able lift arm, was limited ROM (range of motion) and was guarding shoulder." V16 stated, this was new onset pain in R1's left shoulder. V16 stated, R1 said R1 "got into it" with a staff member (V4). V16 stated, "Pain can cause the limited range of motion." When asked what effect on a resident if someone has the resident's arm and is moving the resident by that arm, V16 stated, "It could be dislocated or

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fracture." When asked could an affect on the resident (being moved by someone grabbing the arm) be musculoskeletal strain of the shoulder, V16 stated, "Yes, it could occur from moving resident with (that) arm. Torque the shoulder." When asked if having a person with their hand on a resident's arm and moving the resident with that arm, could it cause a musculoskeletal strain of the shoulder? V16 stated, "Yes especially for the elderly. (R1) had weight loss and deconditioning too." When asked does pain from a musculoskeletal strain occur right away, V16 stated, "No, it would cause some people to take a few days for pain." V16 stated, the previous date that V16 assessed R1 in the facility (on 4/11/23), "(R1) had no pain or ROM deficits."

In R1's Progress Note, dated 4/20/23 at 5:15 pm, V16 (NP) documents, in part, "Left shoulder xray not completed. (R1) c/o (complains of) pain with limited ROM. Send (R1) to (hospital emergency department) for evaluation and treatment."

R1's Care Plan, dated 10/8/22, documents, in part, a focus of "(R1) may be at risk for potential abuse r/t (related to) mental/emotional challenges as evidenced by: Dementia," with a goal of "(R1) will free from harm," with interventions of: "Assure (R1) that they are in a safe and secure environment with caring professionals;" "If (R1) is increasingly upset or agitated ruing care, ensure resident is safe. Politely excuse yourself and then report situation to supervisor and re-approach (R1) with assistance or alternative staff;" and "Utilize behavior approaches that attempt to keep (R1) safe and calm by reassurance, redirection, task segmentation, cueing, reminders, re-approaching, reality orientation during care."

R1's document, dated 4/21/23 and titled "Head to

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S9999	Continued From page 8 Toe Skin Assessment," documents, in part a body diagram with the left shoulder circled with "skin abrasion" hand written for R1's left shoulder, and for the comments, "Old skin abrasion to (R1's) L (left) shoulder." Facility policy dated 11/22/2017 and titled "Abuse Prevention Program - Policy," documents, in part, "Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment ... Purpose: the purpose of this policy and the Abuse Prevention Program is to describe the process for identification, assessment, and protection of residents from abuse, neglect, misappropriation of property, and exploitation. This will be accomplished by: ... Orienting and training employees on how to deal with stress and difficult situations, and how to recognize and report occurrences of abuse, neglect, exploitation, and misappropriation of property; establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment; identifying occurrences and patterns of potential mistreatment; immediately protecting residents involved in identified reports of possible abuse, neglect, exploitation, mistreatment, and misappropriation of property ... The facility prohibits abuse, neglect, misappropriation of property, and exploitation of its residents, including verbal, mental, sexual or physical abuse ... The facility has a "no tolerance" philosophy; persons found to have engaged in such conduct will be terminated. Definitions: Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means ... Abuse is also the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish to a resident ... Physical Abuse	S9999		

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S9999	Continued From page 9 is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention ... Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment." (B)	S9999		