

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/02/2024
NAME OF PROVIDER OR SUPPLIER Ryze on the Avenue		STREET ADDRESS, CITY, STATE, ZIP CODE 3400 South Indiana Chicago, IL 60616	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15301</p> <p>Based on interview and record review, the facility failed to ensure two staff members were present during ADL (Activities of Daily Living) for one of three residents (R2) reviewed for falls. This failure resulted in R2 rolling out of bed to the floor and sustaining a hematoma (bruise that forms under the skin when blood vessels are damaged and leak).</p> <p>Findings include:</p> <p>R2's medical record (Face Sheet) documents R2 is a [AGE] year-old admitted to the facility on [DATE] with diagnoses including but not limited to Metabolic Encephalopathy, Muscle Weakness, Need for Assistance with Personal Care, Dysphagia, Unspecified Protein-Calorie Malnutrition, and Adult Failure to Thrive.</p> <p>R2's MDS (Minimum Data Set of 5/9/2024) documents:</p> <p>-BIMS (Brief Interview for Mental Status) 3 (severely cognitively impaired)</p> <p>-Mobility: Roll left and right: (The ability to roll from lying on back to left and right side and return to lying on back on the bed.) Dependent - Helper does ALL the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity.</p> <p>7/30/2024 at 2:40 PM, V2 (Director of Nursing/DON) said R2 had a fall from bed during ADL (Activities of Daily Living) care. Staff (V11) turned resident too far and R2 fell out of bed.</p> <p>7/31/2024 at 2:59 PM, V11 (Certified Nursing Assistant/CNA) said she was the CNA responsible at the time of R2's fall. Me and V12 (CNA) put her back into bed, from her wheelchair to her bed using the mechanical lift. V12 went to bathroom to get towel wet, get soap and R2 just rolled out of bed. When surveyor said that R2 was extensive/totally dependent upon staff for bed mobility, V11 said some residents just move. V11 said, I started to remove R2's diaper when V12 was in the bathroom, and she rolled over. I tried to grab her, but she fell to the floor. The bed was at about waist level. She just hit the floor. I believe R2 had a bump on her head.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>7/31/2024 at 3:39 PM, V12 (CNA) said, I went to the linen room to get towels. When I came back, R2 was on the floor, on bedside mat. V11 was at the side of the lady. V11 told me she went to roll R2 and R2 rolled out of bed. Bed at low level. Bed was lower than when I left to get linen. R2 has contractures if you roll (a resident who has contractures) you need to hold them, so they don't fall. I don't think R2 could roll herself.</p> <p>7/23/2024 20:41 Nursing Note documents in part: Resident sustained a witnessed fall. Resident rolled to floor while attempting to reposition and provided ADL care in bed, fall mats in place. Raised quarter sized area to left side of forehead, skin intact. Resident assisted back to bed with 2 persons assist with (Mechanical lift). MD was notified of the incident, with orders carried out, family notified. Bed in lowest position, HOB elevated, call light in reach, fall mats in place. All department made aware.</p>		