

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 11/01/2024
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44314</p> <p>Based on interview and record review the facility failed to affirm the right of the resident to be free from verbal abuse. This deficient practice affected 1 (R2) of 8 residents reviewed for abuse.</p> <p>Findings include:</p> <p>Facility's Reported Incident (dated 02/08/2024) states in part: based on the investigation conducted, statements received from residents involved, as well as the employees, both residents were alert and oriented. The residents engaged in a mutual disagreement. No injuries resulted and both residents are safe and comfortable. It may be concluded that there was no intention of either of the residents to inflict any harm on each other. As a result, the facility is unable to substantiate any act of abuse. Staff (V10 Previous Administrator) spoke with R3, and he said, I was going to use the bathroom when my roommate cursed me out and told me to go sit down. We exchanged words, but I didn't hit him with my walker. A staff member heard us and came to separate us. The staff member asked me to leave the room. Staff (V11 nurse) stated, While doing rounds, I heard both R2 and R3 exchanging words. I immediately asked R3 to please leave the room, reported to the nurse on duty. A head-to-toe assessment was done, no injury noted. Pain assessment done; resident reports no pain.</p> <p>R2's Face Sheet documents resident is a [AGE] year-old with diagnoses including but not limited to: hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, unspecified symptoms and signs involving the nervous system, cognitive communication deficit, seborrheic dermatitis, unspecified, gastro-esophageal reflux disease without esophagitis, cerebral infarction, unspecified, nontraumatic intracerebral hemorrhage.</p> <p>MDS (Minimum Data Set) section C (dated [DATE]) documents that R2 has a BIMS (Brief Interview for Mental Status) score of 14, indicating that R2's cognition is intact. MDS section GG (dated Mon [DATE]) documents that R2 does not have the ability to walk or transfer independently.</p> <p>R2's Care plan (dated 06/20/2024) documents that R2 has a self-care deficit in bed mobility related to decreased ability to position or reposition self in bed/ turn from side to side/ move from lying to sitting or sitting to lying position.</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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NAME OF PROVIDER OR SUPPLIER Ryze on the Avenue		STREET ADDRESS, CITY, STATE, ZIP CODE 3400 South Indiana Chicago, IL 60616	
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R3's Face Sheet documents resident is a [AGE] year-old with diagnoses including but not limited to: Conversion disorder with seizures or convulsions, human immunodeficiency virus disease, neutropenia, unspecified, personal history of (healed) traumatic fracture, benign prostatic hyperplasia without lower urinary tract symptoms, major depressive disorder, recurrent, unspecified, disorganized schizophrenia.</p> <p>MDS section C (dated [DATE]) documents that R3 has a BIMS core of 13, indicating that R3's cognition is intact.</p> <p>Care plan (dated 01/26/2024) documents that R3 requires the use of psychotropic medication to assist with managing mood and behavior related to diagnosis of disorganized schizophrenia, major depressive disorder, and conversion disorder with seizures.</p> <p>On 10/30/2024, at 9:39 AM, V1 (Administrator) stated, I am the abuse coordinator. I started my employment at this facility on 06/24/2024, and I am not familiar with what occurred between R2 and R3, because the previous administrator investigated that incident. I let all the employees know that I am the abuse coordinator, and any incidence, observations or reports of abuse should be immediately reported to me and to the supervisor on duty. I also teach the employees the types of abuse, which everyone has on the back of the ID badge as well. Of course, this facility is anti-abuse facility and we do not condone or accept or participate in any forms of abuse. We are always to be proactive and try to anticipate and minimize the chance of abuse occurring. The residents have the right to be free from abuse.</p> <p>On 10/29/2024, at 1:01 PM, Surveyor observed R2 lying in bed comfortably, with the call light within reach. Surveyor interviewed R2 regarding an incident that occurred between R2 and R3. R2 stated, R3 was my roommate at the time. R3 wanted to go out and smoke, and he kept walking back and forth in the room. I was lying down in my bed, and R3 kept pacing back and forth. R3 was agitated because they were not letting him to go out and smoke. I said to R3, Sit your a** down, and I guess he got mad. The next thing I know, he slammed me with his walker. The nurse came in right away. When the nurse came in, R3 said, I'm gonna kill this b****, and he was referring to me. R3 was aggressive and I was scared because I couldn't defend myself. I couldn't defend myself because I can't walk. The nurse removed R3 from the room and they sent him to another facility. R3 was never aggressive towards me before. He hit me with the walker. R3 and I never had any issues before, and I have never seen R3 aggressive towards anyone in the facility. R3 was an old man. He was anxious because he wanted to smoke. He got upset when I said, Sit your a** down. The facility called the police and I have not had a roommate since R3 was transferred out. I feel safe and comfortable in this facility.</p> <p>On 10/30/2024, at 5:21 PM, V11 (Nurse) stated, I don't recall the incident because this was a while ago and I work two other jobs. If I did witness the two residents arguing, I would immediately separate the residents so that the argument does not escalate any further. I would not hesitate to immediately separate the residents who are arguing to prevent the argument from getting physical. Most likely, I did immediate intervene.</p> <p>Incident Statement Authored by V11 (Nurse) (dated 02/05/2024) states: Writer observed resident R3 and his roommate R2 in a heated exchange of words. Resident immediately separated and R3's room was changed to the second floor. No distress for either resident noted.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R2's Progress Note (dated 02/05/2024) documents, It was reported to nurse that resident was hit with a walker by his roommate. Resident stated he asked his roommate to stop moving around too much as he was trying to sleep then roommate hit him with his walker. Head to toe assessment was done, no injury noted. Pain assessment done; resident reports no pain. Dr. made aware. Family made aware. Will continue to monitor.</p> <p>R2's Progress Note (dated 02/05/2024) documents, SSD (Social Service Director) went to speak to resident after incident with roommate. Resident stated that he told his roommate to sit down because they were walking back and forth. The roommate turned around and hit him with their walker. Nursing staff was informed, and the residents were separated immediately. A body assessment was completed, and the nurse informed the physician. Resident stated that his legs were in pain but other than that he was fine. The resident's mother was called and informed of incident. She was upset but glad to hear that there were no damaging injuries. She filed a police report. Social services will continue to monitor and check on resident's well-being.</p> <p>R3's Progress Note (dated 02/05/2024) documents, It was reported to nurse that a resident hit his roommate with his walker. The nurse met with resident to inquire what happened. Resident presents with agitation and not yielding to re-directions. Resident separated from roommate. PRN (as needed) administered.</p> <p>Abuse Policy and Prevention Program (dated 10/2022) states: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility, therefore, prohibits abuse, neglect exploitation, misappropriation of property, and mistreatment of residents. Verbal abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance, regardless of an individual's age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to, threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never to be able to see his/her family again.</p> <p>Resident Rights Policy (undated) states in part: Your rights to safety; You must not be abused, neglected, or exploited by anyone-financially, physically, verbally, mentally, or sexually.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44314</p> <p>Based on observation, interview and record review, the facility failed to administer scheduled pain medication on time for R1, a hospice resident with prostate and bone cancer, in a sample of 5 residents reviewed for pain management.</p> <p>Findings include:</p> <p>R1's Face Sheet documents resident is a [AGE] year-old with diagnoses including but not limited to: Fusion of spine, malignant neoplasm of prostate, secondary malignant neoplasm of bone, elevated prostate specific antigen, muscle weakness, (generalized), benign prostatic hyperplasia, essential (primary) hypertension, anemia.</p> <p>MDS (Minimum Data Set) section C (dated Sep 25, 2024) documents that R1 has a BIMS (Brief Interview for Mental Status) score of 14, indicating that R1's cognition is intact.</p> <p>Care plan (dated 09/25/2024) documents that R1 is on palliative care program related to life limiting illness and a desire not to have aggressive life sustaining measure (i.e. hospitalization s, hospital visits, laboratory draws, and x-rays). Palliative care staff establishes a plan of care with a team approach that includes R1's family.</p> <p>On 10/29/2024, at 11:43 AM, surveyor observed R1 lying in bed with call light within the resident's reach. R1 appeared to be in discomfort. R1 stated, I have not received my scheduled morning pain medication. Nobody brought the pain medication to me yet. There are times that I receive my pain medication late. Sometimes when a new nurse is working the floor, the medication is brought to me late because the nurse does not know the residents and it takes the new nurses longer to administer the medication. I have prostate, bone cancer and I am on hospice. The worst that my pain gets is a 7 out of 10. Right now, since I did not receive my morning pain medication, my pain is at a 7 out of 10.</p> <p>On 10/29/2024, at 11:48 AM, V7 (Licensed Practical Nurse) entered R1's room to administer R1's scheduled medication (9:00 AM). V7 stated, I did not give R1 his 9:00 AM medications and his PRN (as needed) Norco. That is what I am about to give R1. R1's 9:00 AM morphine is being given to R1 right now and I am giving R1 his PRN Norco now as well. I was called in to pick up this shift so that is why I started this shift late. I picked up this shift because they needed the help, so this is the reason why R1 is receiving his 9:00 AM Morphine and his PRN Norco right now. I am about to give R1 his Morphine 30mg and his Norco 10/325mg. I got to R1 as fast as I could but since I started the shift late, that's the only reason why R1's pain medication is delayed. At 11:50AM, surveyor observed V7 administering Morphine 30mg tablet and Norco 10/325mg tablet to R1 for pain management.</p> <p>On 10/29/2024, at 11:57 AM, surveyor performed an inspection of the medication card with V7. Surveyor observed that R1 had 1 Morphine 30mg tablet and 5 Norco 10/325mg tablets remaining in the narcotics locked box.</p> <p>V7's Time Care (dated 10/29/2024) indicated that V7 arrived to work at 8:39 AM.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/30/2024, at 10:27 AM, V2 (Director of Nursing) stated, There have not been any issues with R1 not receiving his pain medications. I am not aware of any issues with R1's pain medication. I have given R1 pain medication that I retrieved from the (medication dispensing device). What happened is that the hospice nurse called me and asked me to give R1 his pain medication from the (medication dispensing device) because hospice was waiting for R1's pain medication to arrive. R1 calls the hospice nurse when R1 needs pain medication instead of asking the floor nurse and the hospice nurse will call me to let me know that R1 needs his PRN medication. There was only that one time that R1's pain medication was not in stock yet and that's when I went and received pain medication from the (medication dispensing device). When a resident with prostate cancer that metastasized to the bone does not receive pain medication on time, it results in increased pain. The morning shift is from 7:00 AM until 3:00 PM. On 10/29/2024, V7 informed me that R1 received his pain medications late. I provided education to V7 and all the nurses in the facility about the importance of administering medications on time. V7 was called in on 10/29/2024, to work the morning shift because one of the nurses that was originally scheduled to work that shift had to go for an IV certification class. This is why V7 had a late start. This is the reason R1's pain medication wasn't administered on time.</p> <p>R1's Physician Order (dated 10/11/2024) states: Morphine Sulfate Oral Tablet 30 MG (Morphine Sulfate) *Controlled Drug*; Give 1 tablet by mouth two times a day for Pain.</p> <p>R1's Physician Order (04/28/2024) states: Norco Oral Tablet 10-325 MG (Hydrocodone-Acetaminophen) *Controlled Drug*. Give 1 tablet by mouth every 4 hours as needed for pain.</p> <p>Pain Management Policy (dated 01/2023) states: To facilitate resident independence, promote resident comfort and preserve resident dignity. This will be accomplished through an effective pain management program, providing our residents the means to receive necessary comfort, exercise greater independence, and enhance dignity and life involvement. Pain management is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goals.</p>		