STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145337	A. Building B. Wing	11/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ryze on the Avenue	3400 South Indiana Chicago, IL 60616

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44103 Based on interviews and record reviews, the facility failed to follow their abuse prevention and residents' rights policies by failing to affirm the right of the resident to be free from abuse and to have a safe environment. This deficient practice affected one resident (R2) with severe cognitive impairment involved in an allegation of physical abuse by another resident (R1) out of three residents reviewed for resident-to-resident abuse. On [DATE], R1 placed a pillow and a blanket over R2's face. Findings Include: R1's clinical records show an admitted [DATE] with included diagnoses not limited to Bipolar Disorder, Depression, and anxiety disorder. R1's Minimum Data Set (MDS) dated [DATE] shows R1 is cognitively impaired and required partial/moderate assistance with activities of daily living (ADL) except for eating and oral hygiene required supervision assistance. R1's behavioral care plan date initiated on [DATE] shows R1 may voice allegations of mistreatment or exploitation by caregivers related to mental illness/psychosis, difficulty controlling anger and depression. R1's progress notes dated [DATE] at 4:00 AM documented by V4 (Registered Nurse) documents in part, When rounding Resident was observed behind her Roommate's bed putting a pillow and blankets on her roommate's face, she was remove (sic) from safety from the room for safety to prevent future occurrences;. R2's clinical records show an admitted [DATE] with included diagnoses not limited to Cerebral Infarction, Aphasia, Dementia, and Dysphagia. R2's MDS dated [DATE] shows R2 has severely impaired cognition and is total dependent on staff's assistance with grooming, personal hygiene, dressing, transfer, and bed mobility. R2's Potential for Abuse and Neglect assessment was completed on [DATE]. No abuse assessment was found prior to [DATE] incident. R2's care plan shows R2 has increased susceptibility to abuse (date initiated [DATE]). R2's progress notes dated [DATE] at 3:53 AM documented by V4 (Registered Nurse) reads in part, When rounding, the Resident's roommate was found in a room trying to be caring to the resident but ended up putting a blanket and her pillow over the resident's face, The Resident was not in distress, and no signs of discomfort were observed; no harm was done to the Resident; Resident was put in a semi-Fowler position to be calm, resident's Family was notified; (son) sets of vitals were taken BP [Blood Pressure] ,d+[DATE], P [Pulse] 84, O2 [Oxygen] sat [Saturation] 98 RA [Room Air]. (continued on next page)

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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's progress notes dated [DATE] at 4:54 PM documented by V15 (Social Service Director/SSD) documents in part, SSD went to speak to resident after incident with roommate. Resident was visibly shaking she is nonverbal she shook her head when asked if she was okay. Nursing staff was informed, residents were separated immediately body assessment completed nurse informed physician. Resident is breathing fine not in distress G-tube feeding going. Resident family was called and informed of incident. Family was upset but glad to hear that there were no damaging injuries and stated they will be filing Police Report. SS [Social Service] will continue to monitor and check on resident's wellbeing. Progress notes written by V15 dated [DATE] at 4:14 PM and [DATE] at 8:21 AM document R2 were resting in bed and not in distress. The facility's final State Report of Abuse Allegation shows alleged victim was R2 and the alleged perpetrator was R1 date of incident [DATE] at 4:00 AM. Summary of investigation documents in part, R2 was sleeping and non-verbal with severe impairment. R1 assumed R2 was dead, and staff found a pillow over R2's head. V6's (Certified Nursing Assistant) documented statement that was obtained by the facility during the investigation of the abuse allegation between R1 and R2 dated [DATE] documents in part: V6 was sitting at the nurses' station. [R1] came out and said [R2] died . R1 was saying belligerent things and V6 followed R1 in the room. V6 opened the curtain moved the cover and pillow that was over R2's mouth. V6 called V9 (Licensed Practical Nurse) and said R2 is shaking too bad epilepsy or anxiety. On [DATE] at 11:13 AM, Surveyor observed R2 lying in bed alert and awake but was not able to make verbal or non-verbal communication. Surveyor attempted to ask R2 questions about the incident that happened on [DATE] with R1, but R2 just stared blankly and did not answer. On [DATE] at 1:06 PM a phone interview was conducted with V6 (CNA). When V6 was asked regarding R1 and R2's incident on [DATE], V6 stated, So I did my rounds at 3:00 AM I walked in their (R1 and R2) room and I saw the privacy curtain was opened and I saw [R2] lying in bed on a fowler's position. The bed was sitting upright around 90 degrees up. I saw there was a pillow on top of [R2's] face and the blanket was pulled up over the pillow covering [R2's] entire body and [R2's] face. As soon as I saw that I removed everything and I called the nurse and both nurses came [V4 - Registered Nurse, V9 - Licensed Practical Nurse]. I had the other CNA (Certified Nursing Assistant) to remove the other resident [R1]. V6 further stated that V4 assessed R2. V6 stated R2 could not talk and could not even do gestures if R2's okay or not. V6 stated R2 looked in distress and per V6, [R2] was having a hard time breathing. V6 stated V4 assessed R2 and monitored R2. V6 stated R2 calmed down later. On [DATE] at 2:26 PM, a phone interview conducted with V9 (Licensed Practical Nurse) and was asked regarding R1 and R2's incident on [DATE]. V9 (LPN) stated that V6 (CNA) called [V9's] attention to R1 and R2's room. When V9 entered the room, R2 looked very agitated and uncomfortable. V9 stated V6 informed [V9] that there was a pillow and blanket on top covering [R2's] face. V9 stated R1 was brought out to the nurses' station and was placed on one-to-one supervision. V9 stated that R2 is non-verbal, bed bound, and could not explain what happened. V9 stated [V9] asked R1 what happened and why the pillow and blanket were on R2's face, R1 answered what did they do with the body. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:58 AM, a phone interview conducted with V4 (Registered Nurse) and was asked regarding R1 and R2's incident on [DATE]. V4 (RN) stated, At around 3:20 AM, [V6] called me to go to [R1 and R2's room]. I went in the room I saw [V6] and [V9] and they were telling me they saw the pillow and blanket over [R2's] face. They already removed it before I came in. I saw [R1] was walking back and forth in the room. V4 stated [V4] asked R1 what happened and R1 answered, I thought she [R2] was dead so I covered her [R2] with the pillow and blanket so that you can carry her body. V4 stated R2 can't speak. V4 stated R2 looked very scared so the staff immediately removed R1 from the room and sat R1 by the nurses' station. On [DATE] at 1:33 PM, interviewed V1 (Administrator) and stated that an example of physical abuse is striking or mishandling another person. V1 stated abuse is a violation or anything that is different from the expectation. V1 stated the residents have the right to be safe and free from abuse while living in the facility. On [DATE] at 2:04 PM, a phone interview conducted with V29 (Nurse Practitioner) and stated R2 has severely impaired cognition, does not talk, and is unable to communicate. When asked if the reasonable person standard is applied, what would R2 had felt when a pillow and a blanket were placed over R2's face. V29 answered, That's brutal. I would fight back thinking are you trying to kill me or something. V29 stated R2 would feel scared and unsafe. The facility's ABUSE POLICY AND PREVENTION PROGRAM dated ,d+[DATE] documents in part: 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. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident. This assumes that all instances of abuse of residents, even those in a coma, cause physical harm or pain or mental anguish. The term willful in the definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. The facility's RESIDENTS' RIGHTS policy (undated) documents in part: The residents have the right to safety, must not be abused and residents' facility must be safe, clean, comfortable and homelike.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47304 Based on interview and record review, the facility failed to properly assess, monitor, and document to prevent further development of pressure ulcers for a resident (R3) identified as high risk. The facility failed to document dressing changes on the treatment administration record (TAR). The facility failed to revise individualized care plan to reflect status of multiple facility acquired pressure ulcers, approaches, and goals for care. The facility also failed to properly assess and complete wound documentation timely for facility acquired pressure ulcers. These failures apply to 1 (R3) out of 3 residents reviewed for pressure ulcers. The findings include: R3's admission record showed admitted on 5/16/2023 with diagnoses not limited to Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right non-dominant side, Unspecified lack of coordination, Weakness, Unspecified glaucoma, Benign prostatic hyperplasia, Encephalopathy, Cerebral infarction, Essential (primary) hypertension, Epilepsy, Aphasia following cerebral infarction, Unspecified dementia. R3's record showed expiration in facility on 8/24/2024. On 11/9/24 at 9:26AM V23 (Wound Care Nurse, Licensed Practical Nurse/LPN) stated she has been working at the facility for about 2 months. She said an assessment to identify the resident if they are at risk for skin breakdown (BRADEN scale) is done upon admission then weekly x 4 weeks, quarterly and as needed for new skin alteration/pressure ulcer. V23 stated if there is a new pressure ulcer, it should be assessed right away and develop or revise the care plan. Assessment includes wound measurement, classification, tissue type, drainage. V23 said there is a wound MD (medical doctor) or NP (nurse practitioner) coming to facility weekly. Reviewed electronic health record (EHR) with V23 and stated R3 with multiple facility acquired pressure ulcers/injuries: 1.Left ankle inner was classified as stage 1 identified on 8/9/24 measured 3.8 x 2.5 x no depth, ended as Unstageable pressure ulcer on 8/23/24 measuring 3.4 x 4.0cm, no depth. 2.Left shoulder started on 7/31/24 classified as Stage 3 measured 10.0 x 5.5 no depth documented. V23 said if it is a Stage 3 there should be a depth because there is an opening, it could have been the wound was not assessed properly. On 8/23/24 it was still classified as Stage 3, measured 13.0 x 7.0 x 0.5cm. V23 said the location, classification and measurement of the wound is not usual and stated, I have seen it before, but it is not usual, it should not be. 3.Left trochanter or hip was classified as DTI (Deep Tissue Injury) on 8/9/24 measured 10.x 8.0cm. On 8/23/24, it was classified as Unstageable measuring 17.0 x 9.0 no depth. V23 stated the wound got necrotic. 4. Left inner heel started on 6/7/24 as Unstageable measuring 7.5 x 3.0 x 0.5cm. It was classified as Stage 4 on 6/23/24. On 8/23/24, pressure ulcer was still classified as Stage 4 measured 7.2 x 3.2 x 0.5cm. 5.Right lower leg was identified on 8/16/24 as Stage 1 measuring 7.0 x 3.0 x 0.0 and ended as Unstageable on 8/23/24 measuring 9.5 x 3.0 x 0.2cm. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6.Right hip classified as Unstageable on 2/1/24 measuring 4.0 x 6.0cm was still Unstageable on 8/23/24 measuring 6.2 x 8.0 x 0.2cm. 7.Right shoulder started on 5/29/24 and classified as Stage 3 measuring 1.5 x 2.0, no depth documented. On 8/23/24, it was classified as Stage 4 measuring 1.5 x 2.0, no depth. V23 said there should have been a depth measurement because it was a Stage 3 and ended up Stage 4, it might not have assessed/measured properly. On 11/9/24 at 11:23AM V2 (Director of Nursing/DON) stated V2 has been working in the facility since 5/1/24. V2 expects the nurses to provide wound care according to the doctor's order and sign or document in TAR (Treatment Administration Record) after wound treatment to show treatment was done or provided. If it is not signed the treatment was not done or if they forget to sign it. V2 said standard of professional nursing practice is if it was not documented it was not done. On 11/9/24 at 1:45PM V29 (Nurse Practitioner) stated the wound care nurse takes care of pressure wounds in the facility. If the wounds are not provided with wound treatments as ordered or if they had missed treatment this could lead to worsening of the wounds. On 11/9/24 at 2:15pm Reviewed R3's wound record with V23 (Wound Care Nurse) and said Left shoulder Stage 3 pressure ulcer was identified on 7/31/24, was not able to find wound assessment/documentation on 7/31/24, the first wound assessment/documentation was dated 8/9/24. Braden scale is an assessment to identify the risk for developing additional or further skin breakdown. Any new pressure ulcer should have a Braden assessment. Reviewed R3's assessment with V23 and stated there are missing assessments for R3's new facility acquired pressure ulcers. V23 said the care plan should be updated or revised to reflect the status of multiple pressure ulcers and to show that the facility developed the plan of care of the residents for the guidance of the staff on how to care for the resident. V23 said after providing treatment sign off in TAR to show Treatment was done or cared for. If it was not signed, it possibly was not done, or they forgot to sign. If treatment is not done as ordered, wound could possibly decline, worsen, potentially could lead to infection. If pressure ulcer is identified, they should do assessment on that day so to keep account of the progression of the wound. If wound assessment was missed or not done timely, they are not able to determine if wound is improving or declining. The size/measurement or classification of the wound could have been different from the date identified to the following day or following week. On 11/9/24 at 3:26pm V2 (DON) stated if wound care treatment is missed or not done, this could set up infection or worsening of the wound. Braden assessments should be completed timely when there is a new pressure ulcer identified to assess resident if they are at risk for skin breakdown. Current status of the wound should reflect in the care plan to keep up the plan of care of the resident. If the care plan is not updated, something could be missed like treatment or care. V2 stated wound assessments and documentation should be done timely or on the date the wound was identified to monitor progress of wound as measurement or classification could change in a day or so and treatment could also change depending on wound assessment. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/10/24 at 10:47 V42 (Wound MD) stated she has been servicing or coming to the facility for at least 2 years and seeing/following residents with pressure or non-pressure wounds. She said if wound treatment was missed for a few days, it is not always that resident's wound would deteriorate or worsen but it could be a factor for wound deterioration or worsening. If a wound is identified, timely documentation and assessment is important as wound measurement or classification could change from today, tomorrow or the following week. MDS dated [DATE] showed R3's cognition was severely impaired. R3 needed total assistance or dependent with eating, oral, toileting and personal hygiene, shower/bathe self, upper and lower body dressing; Substantial/maximal assistance with chair/bed transfer. Always continent of bladder and frequently incontinent of bowel. MDS showed 6 Stage 3 and 4 Unstageable pressure ulcers that were facility acquired or not present upon admission. Reviewed R3's wound assessment details showed in part: 1. Right Trochanter (Hip)- facility acquired, date identified on 2/1/24 as Unstageable. assessment dated [DATE] showed wound measurement: 6.2 (length) x 8.0 (width) x 0.2cm (depth). 2. Right shoulder - facility acquired on 5/29/24 as Stage 3. assessment dated [DATE] showed wound measurement: 2.5 x 7.3 x 0.3cm, clinical Stage IV. 3. Left heel - facility acquired on 6/7/24 as Unstageable. assessment dated [DATE] showed wound measurement: 7.2 x 3.2 x 0.5cm, clinical Stage IV. 4. Left Trochanter (Hip)- facility acquired on 7/31/24 as DTI (Deep Tissue Injury). assessment dated [DATE] showed wound measurement: 17.0 x 9.0, no depth clinical Stage: Unstageable. Facility was not able to provide wound assessment documentation on 7/31/24 date identified. 5. Left shoulder - facility acquired on 7/31/24 as Stage 3. assessment dated [DATE] showed wound measurement: 13.0 x 7.0 x 0.5cm, clinical Stage 3. Facility was not able to provide wound assessment documentation on 7/31/24 date identified. 6. Left ankle inner - facility acquired on 8/9/24 as Stage1. assessment dated [DATE] showed wound measurement: 3.4 x 4.0cm, no depth, clinical Stage - Unstageable. 7. Right lower leg - facility acquired on 8/16/24 as Stage 1. assessment dated [DATE] showed wound measurement: 9.5 x 3.0 x 0.2cm, clinical stage - Unstageable. R3's TAR (Treatment Administration Record) showed but not limited to: -Right hip pressure ulcer treatment was not signed as wound care was provided on 6/3/24, 6/17/24, 6/26/24. June 2024 TAR orders: Cleanse RT (right) hip with NSS (Normal Saline Solution), skin prep peri-wound, apply honey gel cover with hydrocolloid one time a day every Mon, Wed, Fri. -Left Heel pressure ulcer treatment was not signed that wound care was provided on 6/17/24, 6/26/24. June 2024 TAR orders: Cleanse with NSS, pat dry, apply (honey gel) then cover with a dry dressing every M-W-F and PRN one time a day every Mon, Wed, Fri for wound healing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Right shoulder pressure ulcer treatment was not signed that wound care was provided on 6/3/24, 6/17/24, 6/26/24 June 2024 TAR orders: Rt shoulder: clean with NSS, pat dry, skin prep, add honey, apply foam dressing one time a day every Mon, Wed, Fri for wound care. -Left ankle inner was identified on 8/9/24, no treatment signed as provided on 8/9/24 to 8/18/24. August 2024 TAR orders: Lt ankle inner: Cleanse with NSS, pat dry, apply honey and cover with gauze (with border). -Left shoulder was identified on 7/31/24, no treatment signed as provided on 8/1/24 to 8/18/24. August 2024 TAR orders: Lt Shoulder: Cleanse with NSS, pat dry, apply honey and cover with gauze (with border) one time a day every Mon, Wed, Fri for wound healing. -Left trochanter (hip) was identified on 7/31/24, no treatment signed as provided on 8/1/24 to 8/18/24. August 2024 TAR orders: Lt trochanter (hip): cleanse with NSS, pat dry, apply honey cover with gauze (with border) one time a day every Mon, Wed, Fri for wound healing. -Right lower leg was identified on 8/16/24, no treatment signed as provided on 8/16/24 to 8/18/24. August 2024 TAR orders: Rt lower leg: Cleanse with NSS, pat dry, cover with gauze (with border) one time a day every Mon, Wed, Fri for wound healing. R3's care plan reviewed and did not reflect skin alteration on left inner ankle, facility acquired pressure ulcer on 8/9/24. R3's risk assessment (Braden scale) history reviewed, no documentation found that assessment was completed/done on 5/29/24, 6/7/24, 7/31/24, 8/9/24, 8/16/24 when multiple facility acquired pressure ulcers were identified. Facility was not able to provide assessments despite several requests. Facility's policy for skin management: Monitoring of wounds and documentation dated 1/2024 showed in part: it is important that the facility have a system in place to assure that the protocols for daily monitoring and for periodic documentation of measurements, terminology, frequency of assessment, and documentation are implemented consistently throughout the facility. With each dressing change or at least weekly (and more often when indicated by wound complications or changes in wound characteristics), an evaluation of the PU (pressure ulcer) should be documented, at a minimum, documentation should include the date observed and location and staging, size, exudate, pain if present, description of wound edges and surrounding tissue. If a wound shows no signs of healing after three weeks, a reevaluation of the treatment plan including determining whether to continue or modify the current interventions is done. No other policy regarding skin or wound treatment policy and procedures was provided by facility despite several requests.