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	12/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ryze on the Avenue	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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47304 Based on interview and record review, the facility failed to provide appropriate assistance during ADL (activities of daily living) care and follow ADL care plan intervention for use of side rails. The facility also failed to complete fall risk evaluation/assessment in a timely manner. These failures affected 1 (R1) out of 3 residents reviewed for accidents and adequate supervision. R1 had a fall incident on 12/15/24 and sustained a left hip fracture while receiving care. The findings include: R1's admission record showed initial admitted on 6/18/19 with diagnoses not limited to Interstitial pulmonary disease, Rheumatoid arthritis, Unspecified dementia, Other pulmonary embolism, Chronic obstructive pulmonary disease, Schizophrenia, Acute on chronic right heart failure, Gastro-esophageal reflux disease, Depression, Atherosclerotic heart disease of native coronary artery, History of falling, Myocardial infarction, Hyperlipidemia. MDS (Minimum Data Set) dated 10/21/2024 showed R1's cognition was intact. R1 needed substantial/maximal assistance with toileting and personal hygiene, upper and lower body dressing; Partial/moderate assistance with roll left and right on the bed. MDS showed R1 was frequently incontinent of bladder and always incontinent of bowel. MDS coding showed in part: Partial/Moderate Assistance = Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. Substantial/Maximal Assistance = Helper lifts or holds trunk or limbs and provides more than half the effort. R1's POS (Physician Order Sheet) showed in part: May have side rails up when in bed to aide in bed mobility. Order date on 2/7/23 and end date on 12/16/24. Care plan revision date on 7/31/21 documented in part: R1 has an ADL self-care performance deficit r/t (related to) stroke. Bed mobility: R1 requires extensive assistance. Side rails up as per doctor's order for safety during care provision, to assist with bed mobility. R1's latest side rail review assessment effective date 7/27/24 documented in part: Side rails are being used: 1/2 side rail. The resident will utilize side rails that are not considered a restraint and will be utilized to enable the resident to attain and maintain his / her practicable level. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's Fall Risk Evaluation dated 7/26/24 documented in part: Score = 11 (High fall risk). No fall risk evaluation in October found in R1's record. R1's RCA (Root Cause Analysis) read in part: Resident had a fall due to not able to self-stabilize in bed during bed mobility with x 1 assist. Witness statement dated 12/15/24 by V12 (Certified Nursing Assistant/CNA) written in part: V12 went to R1's room to change incontinence pad and do patient care, in the process R1 fell . Nursing progress notes dated 12/15/2024 by V16 (Registered Nurse/RN) documented in part: Approximately at 11:50 the CNA informed V16, R1 had fallen from bed. R1 was observed lying on her left side, next to the left side of her bed. R1 was assessed and reported pain in the left hip. PRN (as needed) Pain medication was administered, and the resident was assisted back to bed in accordance with facility Protocol. A STAT (immediately) X-Ray of the left hip and pelvis was ordered by the MD (medical doctor). X-RAY completed and Resulted in Left Femur intertrochanter fracture. R1's left thigh has increased swelling. MD ordered to send R1 to the hospital for further evaluation. Nursing progress notes dated 12/16/2024 documented in part: R1 admitted with dx (diagnosis) of broken hip. Nursing progress notes dated 12/20/2024 showed in part: R1 readmitted to the facility from the hospital. R1' hospital records - Trauma History and Physical notes dated 12/15/24 showed in part: Left intertrochanteric femur fracture. Admit for ortho for operative fixation. On 12/22/24 at 11:02AM surveyor observed R1 lying on bed, on lowest position, floor mats on both sides, with bed bolster, call light within reach, appears comfortable and well groomed. R1 is alert and verbally responsive. R1 stated to surveyor I don't want to talk to you, go away. On 12/22/24 at 11:10AM surveyor attempted to interview R1 with V8 (Staffing coordinator/CNA) and V9 (CNA) and R1 agreed. R1 able to recall some information regarding the fall incident on 12/15/24, she said she was pushed/slipped from the bed. R1 said she was trying to say a prayer and wanted to be changed. R1 further stated she held onto me and get someone to help her move and slipped from the bed. She said it was a terrible experience. R1 unable to recall staff name. On 12/22/24 at 11:55am V13 (Restorative Director) stated V13 has been working in the facility since April 2024. V13 said on 12/15/24, V12 (CNA) was rendering care (bed mobility/repositioning/cleaning/changing) to R1 and fell from bed. V13 stated in-service was given to V12 regarding bed mobility. V13 said, R1 required partial to substantial assistance x 1 person assist with ADL care. She said R1 was transferred to the hospital due to fall. V13 stated RCA (Root Cause Analysis) was completed, R1 had a fall due to not able to self-stabilize in bed during bed mobility with x 1 assist. Stated R1 is a fall risk. V13 said fall risk assessment is completed upon admission, quarterly and every after fall. V13 stated R1 had fall risk assessment in July and December after the fall incident on 12/15/24 but nothing found for October. V13 stated the purpose of the fall risk assessment/evaluation is to help put all appropriate fall interventions and it will identify if resident is at risk or high risk for fall. V13 said care plan interventions should be followed by staff. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/22/24 at 12:54 PM V14 (Licensed Practical Nurse/LPN) stated has been working in the facility for [AGE] years and transitioned to restorative nurse about 4 months ago. She said on 12/15/24, R1 had a fall incident while V12 (CNA) was rendering care (bed mobility) to R1. V14 said prior to fall: R1 requires 1 -2 assist with ADL care. V14 stated fall incident on 12/15/24 could have been prevented if V12 asked for help or assistance. V14 stated V12 was provided in-servicing regarding bed mobility. V14 stated R1 does not use siderails. She said R1 needed partial assistance with rolling from left to right on bed and substantial assistance with toileting or personal hygiene with 1 person assist. V14 said staff should be holding/supporting the resident while providing care. She said R1 was transferred to the hospital because of the fall incident. On 12/22/24 at 1:27 PM V12 (CNA) stated, V12 has been working in the facility for about 3 months. She said had worked with R1 and on 12/15/24 while providing care by herself, R1's front side was cleaned and was turned in bed on her back. V12 stated, she got a barrier cream in the drawer and R1 slid on the other side of the bed away from her. She said, R1's bed does not have a side rail and R1 can move in bed. V12 stated she told R1, don't move, I guess she moved and slid from the bed. Stated if there was a side rails this fall could be prevented, R1 could have grabbed on the side rail to help / assist with bed mobility. V12 stated she removed her hands or was not holding R1 while reaching out for the moisture barrier cream at bedside drawer. On 12/22/24 at 2:02 PM V16 (RN) stated V16 has been working in the facility since October 2024 and regularly assigned on the 4th floor. Stated on 12/15/24, V12 (CNA) informed her that R1 fell from bed, went to R1's room immediately and saw R1 on the floor lying on her left side with c/o (complaint of) left hip pain. V16 stated, V16 did not see side rails on R1's bed. She said STAT (immediately) x-ray of left hip was completed with result of left femur fracture and R1 was transferred to the hospital. On 12/22/24 at 2:22 PM V2 (Director of Nursing) stated, she was informed by V16 (RN) that R1 fell from bed. She said there was an order for x -ray due to R1's c/o left hip pain; stat x-ray was done in the facility. Result came back that resident has left hip fracture and patient was transferred to the hospital. V2 said, a Fall risk evaluation is done upon admission, quarterly and every after fall to minimize resident risk of falling and identify the risks for fall. If fall risk assessment/evaluation was not completed timely, would not know the risk because resident was not assessed or evaluated. V2 said, the care plan is developed so staff would know what care the resident needs and care plan interventions should be followed, should be appropriate and updated to reflect the status of the resident. V2 said, side rails can be used to aid in bed mobility if resident is able to use it. V2 stated, side rail assessment should be done prior to use to make sure it is not a restraint. V2 said, R1 needed assistance with bed mobility, incontinence care, toileting/personal hygiene, not sure to what extent. Stated if resident required partial/substantial assistance, staff is expected to provide appropriate assistance for resident's safety. On 12/23/24 at 9:39 AM V15 (R1's Nurse Practitioner) stated has been working with R1 and she needed assistance with ADL care. V15 said, in much better situation, R1 should have 2 staff assistance for safety. V15 said, siderails could be used if resident is able to help with bed mobility, something to grab on so that fall could be prevented. If R1 had a fracture, then it was the result from the fall incident that happened. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Facility's bed rails/side rails policy dated 5/2024 documented in part: Bed rails may be used to assist with mobility to ensure that resident maintains the optimal amount of independence. These will be used only after an assessment has been completed. Facility's fall prevention and management policy dated 1/2024 documented in part: While preventing all fall 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. A fall risk evaluation will be completed on admission, readmission, and quarterly significant change and after each fall.