| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145337 | A. Building<br>B. Wing | 01/30/2025 |

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

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30279<br><br>Based on interview and record review the facility failed to ensure that four of six residents (R2, R3, R5 and R6) were free from physical abuse. This failure affected R2, R3, R5 and R6 who had verbal altercation that resulted in physically hitting one another.<br><br>Findings include:<br><br>1.) R2's medical record showed documentation that R2 was admitted on [DATE] with diagnosis list that includes but not limited to Peripheral vascular disease, chronic obstructive pulmonary disease, Acquired absence of right leg, necrotizing fasciitis, complete traumatic amputation, and type2 diabetes mellitus without complications.<br><br>R2's MDS (Minimum Data Set) dated 12/23/2024 showed that R2 had a BIMS scored of 15 indicating no cognitive deficit.<br><br>R2's plan of care for potential abuse last revised date 01/02/2025 showed the goal that R2 will be treated with respect, dignity and reside in the facility free of mistreatment (i.e., abuse and neglect).<br><br>On 01/27/25 at 10:20am, R2 was observed in the bed, when the surveyor asked about the incident of 12/25/24, R2 stated that R3 hit me (R2) in the head and was cursing at me (R2) but I am fine now because I don't want anything to happen to (R3) now or get (R3) arrested. R2 stated that is not okay to hit some-one like that (R3) could have bust me in the head. R2 stated this happened in my (R2) the room.<br><br>2.) R3's medical record Admission Record showed documentation that R3 was admitted [DATE] with diagnosis that includes but not limited to Legal blindness as defined in USA (United State of America), unspecified Glaucoma, and atherosclerotic heart disease of native coronary artery without angina pectoris.<br><br>R3's MDS (Minimum Data Set) dated 12/05/2024 showed that R3 had a BIMS scored of 12 indicating slight cognitive deficit.<br><br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R3's plan of care for potential abuse last revised date 09/17/2024 showed the goal that R3 will be treated with respect, dignity and reside in the facility free of mistreatment (i.e., abuse and neglect).<br><br>On 1/27/25 at 10:23, R3 stated that yes there was a fight, but it is fine now. (R2) hit me and I (R3) hit (R2) back.<br><br>On 1/27/25 at 10:38am, V17 (Social Worker) stated that she is the social worker for the 4th floor, but she did not witness the incident. V17 stated R3 is legally blind, very manipulative, accusatory, and can get upset easily. V17 stated R2 can get upset easily. When asked whether it is appropriate for resident to physically hit each other and whether physical hitting another resident is a form of abuse. V17 stated I was not present in the facility but physically hitting another resident is a physical abuse.<br><br>Facility summary of investigation documented in part that (R2) rode past (R3) in the wheelchair in the hallway and called R3 out R3's name as (R2) went pass R3. R3 allegedly followed behind R2 to the room and allegedly struck R2. The incident was unwitnessed.<br><br>V21 (Licensed Practical Nurse/LPN's) Event Investigation Questionnaire documentation presented dated 12/25/24. V21 documented in part that I (V21) observed R2 sitting in his wheelchair at the foot of the bed swinging both arms/hands making contact to peer's body (referring to R3). R3's documentation showed R3 was sent to the local hospital for complaint of pain to the back of the neck area.<br><br>On 1/29/25 at 3:22pm, V21 (LPN) assigned to R2 and R3 stated that she was passing medications in the hallway and heard the residents yelling and telling R3 not to go into R2's bedroom. V21 stated that she saw R3 in R2's room swinging his arms and hitting R2. V21 stated that she did not see both residents R2 and R3 when the fight started because they were coming out of the elevator from smoking time. V21 stated I assessed R2 and R3 and there was no apparent injury but when the police arrived at the facility R3 stated that (R3) will like to go to the hospital because of pain to the back of the neck. V21 stated that the physician ordered for R3 to be sent to the hospital. R3 returned to the facility without any injury.<br><br>R3's medical record progress note showed V21 documentation that R3 was sent to the local hospital for complaint of pain to the back of the neck area.<br><br>3.) R5's medical record Admission Record showed documentation that R5 was admitted to the facility on [DATE] with listed diagnosis that includes Cerebral Infarction unspecified, nicotine dependence unspecified, other psychoactive substance, essential hypertension dysarthria and anarthria, Major depressive disorder, Dysphagia, oropharyngeal phase, and long term (current) use of aspirin.<br><br>R5's MDS (Minimum Data Set) showed that R5 had a BIMS scored of 15 indicating no cognitive deficit.<br><br>On 01/27/25 at 9:52am, R5 observed in bed and awake. When asked about the incident of 01/11/25, R5 stated (R6) was upset for something I don't know and then R6 just started cursing me call me N**** word and B**** word. When I told R6 to stop, R6 started hitting me in the face. It hurts and I hit R6 back. R6 picked a fight with me. R5 stated R6 is gone now, I don't have to worry about R6 because R6 threatened me about hurting me and others in this place (Referring to other residents).<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 4.) R6 medical record Admission Record showed documentation that R6 was admitted to the facility on [DATE] with diagnosis that includes but not limited to bipolar disorder, current episode mixed moderate, anxiety disorder and Parkinson disease without dyskinesia.<br><br>R6's MDS (Minimum Data Set) showed that R6 had a BIMS scored of 15 indicating no cognitive deficit.<br><br>R6's plan of care initiated dated 1/09/25 for behavior documented that R6 has a history of verbal aggression, inappropriate, attentions-seeking and/or maladaptive behavior.<br><br>On 1/27/25 at 11:28am V15 (Social Services Director) stated that R6 came into the facility (referring to at Admission) verbally aggressive. V15 stated R6 was sent to the hospital but did not come back to the facility. V15 stated R6 did not want to come back to the facility. The surveyor asked whether R6 was on any therapeutic program for aggressive behavior since this behavior is a known behavior. V15 stated that R6 did not stay in the facility long enough for this to be address. When asked whether hitting another resident is an appropriate behavior, V15 stated that hitting another resident in cases of resident-to-resident altercation can be a form of abuse.<br><br>On 1/27/25 at 11:39pm, V14 (LPN) stated that on 1/11/25, I (V14) was the supervisor on that shift 3pm to 11pm. Another nurse was the direct nurse (referring to V24) for (R5 and R6). I (V14) was in the nursing office, and I (V14) overheard a resident yelling that they are fighting (referring to R5 and R6) but at the time I (V14) did not know it was (R5) and (R6). I (V14) opened the door and there was no one in the hallway but I (V14) can still hear the noise. Then I (V14) heard R5 yelling you all better come and get her (referring to R6). I (V14) ran into the room and another nurse who came out the elevator was behind me. When I got to the room, both (R5 and R6) were standing about one to two feet apart sweating, breathing heavily with their hair looking like they have pulled each other hair.<br><br>On 1/27/25 at 1:44pm V14 stated that, one (referring to self) can tell that they have being fighting like in a physical altercation both of their hair looks the same. I (V14) assessed both R5 and R6, R5 had no injury but R6 had a small scratch to the left side of the nose on the face. I (V14) cleaned it with normal saline. V14 stated that R5 had no injury and asked (R5) if R5 was in pain. R5 said she was in a little pain and declined pain medicine. V14 stated that when I asked both (referring to R5 and R6) about what caused the altercation, they both said she hit me first. Pointing at each other. R5 said R6 was calling (R5) N**** word and B*** word.<br><br>On 1/27/25 at 1:53pm, V14 stated that R6 is known for been verbally abusive and aggressive towards staff and peers and this was path of the diagnosis. Calling them (staff and peers) out of their names. We (staff) separated them. R5 was taken to the nurse's station because R6 will not leave.<br><br>The local police department was called, social services, administrator, DON (Director of Nurses), ADON (Assistant Director of Nurses), and the doctor were notified. A police report was filled. The doctor wanted R6 petitioned out to the hospital for evaluation and treatment because R6 has been having behavior problem issues.<br><br>When asked about V14's professional opinion whether this incident of physical assault on 1/11/25 can be a form of abuse. V14 stated that an abuse is an abuse, I (V14) believe R6 was abusive towards R5. Yes, R6 was abusive.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | V23 (Certified Nursing Assistant/CNA) assigned to R5 and R6 statement presented as part of facility investigation dated 1/11/24 (referring to 1/11/25), V23 documented on a paper statement that I did not witness anything.<br><br>V24 (Nurse) documented that I did not witness the physical fight between the two residents (R5 and R6). Only verbal abuse and threatening altercation was heard at a distance.<br><br>On 1/29/25 at 3:10pm, interview conducted with V1 (Administrator) regarding types of abuse whether physically hitting resident to resident is appropriate and can be regarded as a form of abuse. V1 stated physical hitting of resident is a form of physical abuse. V1 stated it is an abuse because a bodily contact is made. V1 stated that was why the incidents were reported.<br><br>On 1/29/25 at 4:38pm, V24 stated that I was with another resident at the time of the incident on 1/11/25. V24 stated I heard the verbal foul language been uttered by R6. V24 stated it later turned to physical hitting, but I did not witness that. They (R5 and R6) were separated. When asked about physically hitting peers being a form abuse. V24 stated hitting another resident or staff hitting a resident is considered an abuse.<br><br>On 1/29/25 at 4:42pm, V23 (CNA) stated that on 1/11/25, I did not witness the physical fight. I (V23) hardly work on this floor, but I was told there was a fight between two residents (referring to R5 and R6)<br><br>The facility Abuse Policy and Prevention Program presented dated 10-2022 documented that the facility affirms the right of our residents to be free from abuse that includes mistreatment. This facility therefore prohibits abuse that includes mistreatment of residents. The purpose of the policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse that includes mistreatment of residents.<br><br>The policy defines abuse that includes any physical/ mental injury inflicted upon a resident other than by accidental means. 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. Listed examples of physical abuse includes hitting and slapping. |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide for the safe, appropriate administration of IV fluids for a resident when needed.<br><br>30279<br><br>Based on observation, interview, and record review the facility failed to follow generally accepted stand of professional practice when administering IV (Intravenous) fluids rate as ordered by physician for 5 of 5 residents (R8, R9, R10, R11, and R12) reviewed in the sample for IV therapy. This failure affected R8, R9, R10, R11, and R12 who were receiving IV fluid were observed not infusing at the right drip rate per minute to infuse 1000ml/hour as ordered. This has potential to affect all 73 residents listed as getting IV therapy.<br><br>Findings include:<br><br>On 1/22/25 at 10:40am, R8 noted in the room with an IV 1000ML bag infusing rapidly with flow meter left at open rate. No label to show the start time and no stop time. Highest calibration noted on the flow meter was 250ml/hour which will equal to 4 hours of infusion. V3 (Registered Nurse/RN) in charge of R8 stated that I (V3) don't do anything with the IV, there is an outside company that takes care of that. R8 stated that I (R8) would like to go in the bathroom, and I (R8) don't know what to do now should I carry it to the bathroom (referring to the IV pole) asking the surveyor. At 10:45am, when this observation was shown to V2 (Director of Nurse/DON) and V29 (Nurse Consultant). V2 and V29 both stated that the drip rate is too fast. V2 and V29 were unable to determine the drip rate. V29 stated that the IV infusion therapy nurse should be called to explain self.<br><br>On 1/22/25 at 11:10am, V4 (RN from IV therapy infusing company) when this was shown, stated there was no way to infuse it at 1000ml/hr. as it was ordered because the (flow meter) calibration is at highest 250ml/hr. and using that it will take four hours to get the fluid into the resident, so I just leave it open. When asked whether this was communicated to the physician who ordered the medication. V4 stated that all I (V4) must do is to just speed the remaining solution up and at times it goes over one hour. V4 stated for R8 IV was started at 10:25am.<br><br>When asked why the bag was not labeled. V4 could not present any documentation of vitals before and after infusion and did not answer the question. V4 stated that the flow meter in use has a 15 drops/ml. V4 stated that the fluid includes nutritional supplement and vitamins. The surveyor then asks V4 with 15 drops/ml delivery the 1000ml will not be infused in one hour. V4 stated all I (V4) must do is to just speed the remaining solution up and at times it goes over one hour.<br><br>On 1/22/25 at 11:20am V29 (Nurse consultant) stated any IV infusion should be given per physician order.<br><br>On 1/22/25 at 11:23am V2 (DON) stated that if a flowmeter or IV pump is not used to infuse the IV fluid, V4 should have counted drip per minute to follow the physician of 1000ml/hr. V2 stated that is not professionally accepted in nursing for safety reasons for resident not to have fluid overload. When asked what can happen to a resident if fluid is infused rapidly. V2 stated in resident with CHF (Congestive Heart Failure), with resident on dialysis or in respiratory distress this can be a serious problem. V2 stated the facility nurses on the floor does not monitor the infusion the consulted RN is performing the infusion are supposed to monitor the flow rate, use the right equipment (referring to flow meter device) and the residents.<br><br>(continued on next page) |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 1/22/25 at 11:30am, on the 4th floor R9 and R10 was noted with IV infusion and same flow meter left on open calibration. V5 (Licensed Practical Nurse/LPN) stated I (V5) was wandering why the fluid was running that fast, but we (facility Nurses) have been told not to worry about the IV because the consulting IV people will be in charge (oversee) of the IV. But I (V5) can tell this is too fast. R5 stated there is no labeling of time it started or will end.<br><br>On 1/22/25 at 11:44am, R11 noted in bed with IV infusion infusing at an open rate on the flow meter. V6 (RN) stated this is like just infusing without any rate. V6 stated I did not know when it was started it is not written on the IV bag but if I am the nurse giving it (administering the fluid) as a nurse I (V6) will label the infusing bag with time and rate it should be going to the resident (infusing). V6 stated that we (referring to facility licensed Nurses) don't do anything with the IV supplement infusing there is a company nurses that monitor that, but the IV therapy nurse is not on the floor right now.<br><br>On 1/22/25 at 11:49am, R12 noted in the dining room with peers in activity waiting for lunch, IV infusing noted. V7 (RN from IV therapy infusing company) walked out of the elevator and was asked about the infusion rate setting and labeling of the IV bag with time started and ending time. V7 stated the flow meter has a calibration of 60 drops per hour so we just set it at open rate and the remainder we just speed it up to infuse if there is any fluid left. V7 presented unused IV administration set that showed 15 drops/ml (milliliter) not 60 drops/ml. V7 stated with this there is usually some small amount left in the bag and then when I (V7) return to the (resident) that I (V7) am taking care of I will just speed it up. V7 then walked to the dining area where R12 was sitting with peers present and disconnect the IV from R12 with some of the fluid left in the bag.<br><br>On 1/22/25 at 1:28pm, V12 (Regional Operations Manager of the IV therapy company) stated that the 1000ml bag should be infusing at 15 drops/ml. When asked at what drops should that be calculated. V12 stated that the (flowmeter) on the IV administration set is 15 drops/ml but I am not a nurse if the 250ml/hour on the set is used the IV will have to infused for 4 hours and the order was 1000ml/1 hour. V12 stated there is no pumping machine device to be used by the infusion nurses so they must have 250ml in the fluid chamber that is how it is counted. The surveyor asked V12 to clarify 250ml in the infusion IV set. V12 stated that is how it is counted. Maybe I (V12) will have to get our nurse consultant for you (referring to the surveyor) on the phone. In the telephone conversation V13 (VP Clinical Operations RN) stated that with the (flowmeter) used the highest rate is 250ml/hr. V13 stated in part that with this calibration it will take 1000ml to infuse for 4 hrs. V13 stated the that the 1000ml/hr. should be infusing at 250 drops/minute.<br><br>Review of R8, R9, R10, R11 and R12 medical record Physician Order sheet showed that the IV bag 1000ml should infuse at 1000ml/1hr(hour). This order was not followed.<br><br>Review of R8, R9, R10, R11 and R12 medical record progress notes showed documentation that the IV therapy were administered completely within the 1 hour as ordered.<br><br>(continued on next page) |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The facility presented Educational In-Service titled Calculating Drip Rates for Infusion dated 1/28/25 with objective indicating that by the end of the in-service session the nurses will be able to confidently calculate drip rates for IV infusion using step by step approach, ensuring the correct flow rate is maintained for optimal patient care. Formula listed to calculate drip rate showed that with 1000ml/hour bag the drop rate should be 250gtt/min (Drops/Minute) this formula was not followed. Under educational review it showed documentation that accurately calculating drip rate is essential in providing safe and effective IV infusions.<br><br>The facility policy on Medication Administration documented that all medications are to be administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis. Listed guideline includes but not limited to if the physician order cannot be followed for any reason, the physician should be notified in a timely manner (depending on the situation) and a note should reflect the situation in the resident's medical record. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>30279<br><br>Based on observation, interview, and record review the facility failed to ensure that the medication cart was locked when not in visual proximity of the nurse and not in use to prevent tampering and accidental hazard. This failure has the potential to affect all the 73- residents residing on the 4th floor.<br><br>Findings include:<br><br>On 01/27/25 at 1:30pm, on the 4th floor medication cart was noted in the hallway unlocked and not in visual view of the nurse. R14 was observed standing by the cart while V14 (Licensed Practical Nurse/LPN) was in a patient room. The surveyor asked R14 where the nurse is, R14 stated V14 went into that room and was waiting here for V14 to come out.<br><br>On 1/27/25 at 1:33pm, when this observation was shown to V14 and was asked about the facility policy on medication/medication cart storage, V14 stated I should have locked the cart when I went into the patient's room for safety.<br><br>On 1/27/25 at 2:18pm, when the surveyor made V16 (Assistant Director of Nurses/ADON) aware of the observation and was asked about the facility policy on medication cart storage and the expectation of the nurses when medication cart is not in view of the nurse and not locked. V16 stated that if they (referring to the nurses) must walk away or have their back turned (Referring to away from the cart). They must lock the medication cart.<br><br>Medications and biologicals are stored safety, securely, and properly following the manufacture or supplier recommendations. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Responsible party listed is Nursing. Listed procedure includes but not limited to medication carts and medication supplies are locked or attended by person with authorized access.<br><br>The facility policy on Medication Administration documented under guidelines that never leave the medication cart open and unattended. |