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	03/25/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45111 Based on interviews and records review, the facility failed to notify a representative for one (R7) of three residents reviewed of change in condition in a total sample of 14 residents. Findings include: R7 is a [AGE] year-old individual admitted to the facility on [DATE]. R7's current face sheet documents R7's medical conditions to include but not limited to: benign neoplasm of right breast, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, other specified abnormal uterine and vaginal bleeding, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. R7's MDS (Minimum Data Set) section C (Cognitive Patterns) dated 1/27/2025, documents R7's Brief Interview for Mental Status (BIMS) as 14/15 indicating R7 has intact cognition abilities. Section GG - Functional Abilities documents R7' abilities as: Eating/ Oral Hygiene-Supervision or touching assistance, Toileting Hygiene-Substantial/maximal assistance, Shower/bathe self-Substantial/maximal assistance, Upper body dressing-Substantial/maximal assistance, Lower body dressing-Substantial/maximal assistance, putting on/taking off footwear-Substantial/maximal assistance, Personal Hygiene-Substantial/maximal assistance, and R7 uses a motorized scooter. On 03/19/2025 at 2:25 PM, R7 was observed lying in bed awake and stated not too long ago she was bleeding out of her vagina. She saw it when she was assisted to the bathroom. R7 stated she has gone through menopause and was worried when two days after she started bleeding, she was sent to the hospital. R7 stated her daughter was notified the day R7 went to the hospital but she does not know if she was notified when R7 started bleeding. R7's progress notes dated 2/16/2025, 6:11 AM, by V8 (Licensed Practical Nurse/LPN) documents Certified Nursing Assistant/CNA (no name provided) brought to V8's attention that resident (R7) is bleeding vaginally and passing big clots. Writer (V8) went to assess R7 and saw clots. V8 will notify MD (Medical Doctor), DON (Director of Nursing), Family, and next shift nurse. Review of R7's progress notes document R7 was sent to the hospital on 02/18/2024. R7's family member contact was attempted on 2/18/2025 and the family was not reached. R7's progress notes do not document R7's family was attempted to be reached on 2/16/2025 and 2/17/2025. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/21/2025, at 10:52 AM, V18 (LPN) stated if a resident has a change in condition, the nurse notifies the doctor, DON, and resident's family member(s) the same day and charts it in the progress notes who was notified. V18 stated the nursing progress notes should read notified and not will notify because will notify is in the future and is not carried out yet. On 03/21/2025, at 12:15 PM, V12 (LPN) stated if a resident has a change in condition, the nurse notifies the doctor, the Director of Nursing, and the family. Then the nurse documents in the progress notes. V12 stated when a nurse documents in the progress notes will notify doctor, Director of Nursing, and family member, it means that the nurse has the intentions of contacting the doctor, DON and family member but has not done it yet. V12 stated once the nurse notifies the doctor, DON and family member, progress notes should read they were notified even if they were not reached. On 03/21/2025, at 2:50 PM, V2 (DON) stated V8's (LPN) documentation on R7's progress notes dated 2/16/2025, 6:11 AM, stating V8 will notify MD (Medical Doctor), DON (Director of Nursing) , family, and the next shift nurse are charted in the future and do not document that R7's family was notified of R7's change in condition on the day R7 had a change in condition. V2 stated if it's not documented correctly, it's not done. Facility policy titled Change in Resident Condition dated 1/10/2024, documents: -It is the policy of the facility except in a medical emergency, to alert the resident, residents' physician, and resident party of a change in condition.

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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 - 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** 45000 Based on interview and record review, the facility failed to prevent and protect two residents (R1, R5) from resident-to-resident abuse out of four residents reviewed for physical assault in a total sample of 14 residents. This failure resulted in R5 falling in the facility and sustaining a pneumothorax and several fractured ribs. Findings include: 1.) On 03/18/2025, at 3:22 PM, R5 states herself and her former roommate (identified as R12) were arguing because R12 never cleaned and never showered. R5 states she was encouraging R12 to clean up and take a shower. R5 states R12 then told her to shut the f**k up. R5 states she then told R12, I'm not a kid, don't tell me to shut up. R5 states R12 then took a gray colored water pitcher with water inside and threw the water on R5. R5 states she tried to cover herself by placing her hands up over her face. R5 states in the process, she slipped on the water that R12 threw at her. R5 states she hit her chest when she fell . R5 states the facility called the ambulance and she was taken to the hospital and had broken ribs. R5 states she was moved to another room when she returned from the hospital. R5 states herself and her new roommate get along well without any problems. R5 states she sees R12 in the facility and has not had any other problems with R12 since then. On 03/18/2025, at 3:30 PM, R12 states R5 was upset with her and wanted to argue. R12 states R5 had an attitude with her and wanted to fight. R12 states she threw water on R5 to calm her down. R12 states R5 slipped and fell over by the window and was taken out of the facility by the ambulance. R12 states herself and R5 are no longer roommates and when R5 returned from the hospital, R5 was moved to another room. R12 states she sees R5 in the facility but no longer speaks to R5. On 03/19/2025, at 1:39 PM, V8 (Licensed Practical Nurse/ LPN), states a CNA (Certified Nursing Assistant) came to notify her that R5 was moaning in pain and her left side was hurting. V8 states when she arrived to R5s' room, R5 informed her that she slipped, fell , and hit her side on the railing of her bed. V8 states R5 informed her that R5 fell on the previous shift. V8 states she asked R5 why R5 did not report it on the previous shift and R5 told V8 that R5 was not in pain then. V8 states she assessed R5 and R5s' side was red in color. V8 states she called the doctor and the Director of Nursing/DON (identified as V2) to notify them, but they did not pick up the phone. V8 states she then informed the supervisor on duty and the supervisor advised V8 to send R5 out to the hospital. V8 states she called the ambulance and sent R5 to the emergency room to be evaluated. V8 states she later was informed by V2 that V2 was made aware that R5 had a squabble with her former roommate (identified as R12). V8 states she was never informed by R5 that R5 was involved in an altercation with R12. V8 states she also informed V2 that V8 was not made aware of any altercations between R5 and R12. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 03/19/2025, at 3:18 PM, V2 (Director of Nursing/DON) states she was made aware by V8 (LPN) that R5 had a fall and was complaining of pain. V2 states R5 was then sent to the hospital to be evaluated. V2 states she was made aware via R5's hospital records that R5 reported that she slipped on water and fell in the facility. V2 states R5 did not originally report this to the facility. V2 states she then initiated an investigation for R5's fall. V2 states through her investigation, she was made aware that R5 and R12 had a disagreement about R5 making noise while R12 was trying to sleep. V2 states with further investigation, she was made aware that R12 alleged that R5 touched R12's shoulder. V2 states she informed V1 (Administrator) and V1 was responsible for following up with this allegation. V2 states she handles fall reportables (facility required documentation/report notifying the state surveying agency of an incident involving a resident) and V1 handles abuse reportables. V2 states she reported R5's fall to the state agency within the required time frame. On 03/21//2025, at 9:12 AM, V1 (Administrator) states she is the abuse coordinator, and she was made aware by V2 (DON) of the altercation between R5 and R12. V1 states she spoke with R12 and R12 informed her that R5 hit R12 because R5 was making noise and R12 asked R5 to stop. V1 states R12 told V1 that R12 may have thrown some water near R5 and then sat back down on R12's bed and R12 left it alone. V1 states she conducted an investigation and was made aware that R5 possibly slipped on some water. V1 states she spoke with R5 and R5 informed V1 that R12 threw water on R5. V1 states she was made aware that R5 may have fallen later after the altercation between R5 and R12. V1 states R5 did not use the verbiage that R5 fell on the water that R12 threw at R5. V1 states she reported this incident to the state agency within the required time frame. R5's Face sheet documents that R5 has diagnoses not limited to: Multiple fractures of ribs, left side, subsequent encounter for fracture with routine healing, traumatic hemopneumothorax, subsequent encounter, unspecified fall, sequela, and vitamin D deficiency. R5's MDS/Minimum Data Set, dated dated dated [DATE], documents that R5 has a BIMS/Brief Interview for Mental Status of 9/15, indicating that R5 is moderately cognitively impaired. R5 requires substantial/maximum assistance with ADL/Activities of Daily Living care. R5 is incontinent of bladder and bowel. R5 ambulates via walker. R5's care plan dated 03/10/2025. documents R5 has 4th/6th rib Fracture r/t Fall. R5 had a traumatic hemopneumothorax. R5s' care plan dated 03/11/2025 documents Encourage resident to report all spills to staff immediately. R5s' care plan also documents that R5 is at high risk for falls. R5's hospital records dated 03/07/2025, documents that R5 has diagnoses of small left pneumothorax, acute, displaced fracture of the left fourth and sixth through ninth ribs. R5 was admitted to the hospital on 03/02/2025, due to bleeding and chest injury. R12's Face sheet documents that R12 has diagnoses not limited to: unspecified dementia, cerebral infarction, type 2 diabetes mellitus, essential hypertension, and chronic viral hepatitis C. R12's MDS/Minimum Data Set, dated dated dated [DATE], R12 has a BIMS/Brief Interview for Mental Status of 13/15, indicating that R12 is cognitively intact. R12 requires supervision assistance with ADL/Activities of Daily Living care. R12 is incontinent of bladder and bowel and ambulates via walking. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	R12's behavior assessment dated [DATE] documents that R12 was physically aggressive towards her roommate (identified as R5). Nursing progress note dated 03/02/2025, written by V8 (LPN) at 5:13 AM, documents R5 explains to writer that she had a fall on the previous shift and is screaming in severe pain in her left side ribs. R5 says that it hurts when she tries to move. Supervisor was notified and suggested to send R5 out to hospital for further evaluation. Nursing progress note dated 03/02/2025, at 6:15 PM documents R5 admitted to hospital with admitting diagnosis trauma, multiple rib fractures. Record review documents that R5 resided in the same as R12 on 03/02/2025. Ombudsman Residents' Rights for People in Long-Term Care Facilities dated 11/2028 documents in part, You must not be abused, neglected, or exploited by anyone - financially, physically, verbally, mentally, or sexually. 45001 2.) According to R1's face sheet and MDS 2/28/25 provided by facility, R1 has diagnoses that include but not limited to Alzheimer's disease, anxiety disorder. R1 has a BIMS (Brief Interview for Mental Status) score of 6 indicating severe cognitive impairment and required services of and resided on a specialized dementia/Alzheimer unit. According to R1's care plan provided by facility, R1 is care planned for wandering behavior: R1 demonstrates behavior that may be interpreted as wandering, pacing, or roaming related to the diagnosis of Alzheimer's disease. Symptoms are manifested by pacing, roaming, or wandering in and out of peer's rooms. R1 is care planned for abuse/neglect: R1's comprehensive assessment reveals a history of suspected abuse and/or neglect or factors that may increase his/her susceptibility to abuse/neglect. R1 is care planned for Alzheimer: R1 has diagnosis of Alzheimer's and may display moods/behaviors related to diagnosis such as agitation/aggression. According to R2's face sheet and MDS 1/3/2025, provided by facility, R2 has diagnoses that include but not limited to schizophrenia, restlessness and agitation, type 2 diabetes mellitus. R2 has a BIMS (Brief Interview for Mental Status) score of 13 indicating intact cognition. According to R2 care plan provided by facility, R2 is care planned for behavior: R2 has a history of verbal and physical aggression and threatening staff and peers. The resident has a diagnosis of schizophrenia. On 3/18/25 at 2:50 PM, V25 (Certified Nursing Assistant/CNA) stated V25 heard a scream from R1. I went to see what was going on. This happened in R2's room. When I went into the room there was a CNA (V26) in the room who was trying to get R1 and R2 apart. R2 was in a wheelchair. R1 was standing. R2 had the wheelchair armrest in hand and was hitting R1 in the head with it. R1 wanders in different resident rooms and is known to lay down in their beds. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 3/18/25 at 3:00 PM, V26 (CNA) stated V26 was walking past R2's room and heard R1 saying Stop. I went into the room and saw R2 hitting R1 with an object. R2 did make contact with R1. I immediately called for the nurse. I stood in between them. R2 was in a wheelchair. R1 was standing in R2's room. R1 is a wanderer. I believe R1 went out to the hospital. R2 went out to the hospital and has not been back to the facility. R1 gets confused, tired and wants to sit down. It is typical for R1 to wander into other residents' rooms. R2 is mean and grumpy. R2 has outburst cursing at staff. R1 has dementia. On 3/18/25 at 3:13 PM, V4 (Licensed Practical Nurse/LPN) stated R1 went into R2's room. R1 wanders. R1 started yelling. The CNA called out for help. Me and another nurse went into the room and separated R1 and R2. R2 can be irate. R2 is combative, was always yelling, mean and mad. It was a challenge to give R2 care. R2 mostly yelled and cursed at staff. R2 had the cushion from the wheelchair armrest in hand. I sent R1 and R2 to the hospital. R2 was sent for a psychiatric evaluation. R1 went to the hospital because R1 had redness/abrasion on the forehead and a scratch. I notified the physician, family, and the Director of Nursing. The administrator is the abuse coordinator. I have had abuse in-services within the last month. If I witness abuse I would intervene, separate the residents, and notify the administrator. On 3/21/25 at 12:30 PM, V12 (LPN) stated I was called to the situation. I helped separate the two (R1 and R2). I was at the other end of the unit/floor. I heard the commotion, the CNA yelled for me and said R1 is in the room having an incident with R2. I went to the room. R1 was already out of the room and R2 was wheeling himself to the door to come out of the room saying, R1 was in my room. I stepped in between and closed the door so R2 could not come out. I did not see anything in R2's hands. I monitored R2 until R2 was petitioned out to the hospital. R1 roams a lot, and I have not observed any aggressive behaviors. R2 has random outbursts if someone comes in R2's space/personal space. R2 has said Get away from me. R2 is mostly into himself. On 3/21/25 at 2:40 PM, V1 (Administrator) stated I am the abuse coordinator. I was the Administrator/abuse coordinator at the time of the incident with R1 and R2, on 1/23/25. The last abuse in-service was in 2/25/2025. Some types or abuse are physical, neglect, mental, involuntary seclusion, exploitation, financial. My expectation is for abuse to be reported to me immediately. Residents should be separated immediately. The incident with R1 and R2 was reported to me and my assistant administrator at that time. It was alleged that R2 was agitated and allegedly hit R1. The nurse, V4 (Licensed Practical Nurse), told me that when she went into the room R2 was swinging at R1. V4 said R2 had the cushion from the arm rest in hand. V4 said they immediately separated them and both residents were assessed. There were no injuries observed. Abuse was not substantiated due to the evidence. R1 and R2 were both sent to the hospital for evaluation. R1 came back from the hospital. R2 has not been back since the incident and is not returning. R2 stated R2 does not want to come back to the facility. R2 nursing progress note, 1/23/2025, 11:35 AM, reads in part: resident made physical contact with another resident. Resident stated, Resident entered my room and would not get out. Separated resident from other resident and monitored resident behavior. Resident sent to hospital for psych evaluation and treatment. MD (medical doctor) and family notified of incident and transfer. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	State Report of Abuse Allegation, 1/23/25, reads in part: R1, R2 and staff were interviewed related to the resident-to-resident altercation that occurred. Upon investigation, it was determined that R2 allegedly hit R1 in the forehead although the incident was unwitnessed. Residents were immediately separated to prevent further conflicts and ensure the safety of all residents. R2 was educated on the appropriate procedures for reporting concerns, emphasizing the importance of notifying staff rather than taking matters into their own hands. Both residents were sent out to the hospital for further evaluation. R2 has not returned to the facility at this time. A police report was filed. Alleged victim (R1) orientation is not alert with a diagnosis of Alzheimer's disease. Alleged perpetrator (R2) orientation is alert with a diagnosis of schizophrenia. Facility Abuse Policy and Prevention Program, 10/20/22, reads in part: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation or property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident. Physical abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45000 Based on observation, interview, and record review, the facility failed to provide adequate supervision and monitoring for residents in the dining room. The facility also failed to monitor and track residents who are on fall precautions. This failure affects one of three residents (R4) reviewed for falls. The facility also failed to monitor one resident (R1) with a known history of wandering in the facility. These failures have the potential to affect 73 residents residing on the second floor in the facility. Findings include: 1.) On 3/18/25 and 3/21/25 observed R1 walking in the hallways. According to R1's face sheet and MDS 2/28/25, provide by facility, R1 has diagnoses that include but not limited to Alzheimer's disease, anxiety disorder. R1 has a BIMS (Brief Interview for Mental Status) score of 6 indicating severe cognitive impairment and required services of and resided on a specialized dementia/Alzheimer unit. According to R1's care plan provided by the facility, R1 is care planned for wandering behavior: R1 demonstrates behavior that may be interpreted as wandering, pacing, or roaming related to the diagnosis of Alzheimer's disease. Symptoms are manifested by pacing, roaming, or wandering in and out of peer's rooms. R1 is care planned for abuse/neglect: R1's comprehensive assessment reveals a history of suspected abuse and/or neglect or factors that may increase his/her susceptibility to abuse/neglect. R1 is care planned for Alzheimer: R1 has diagnosis of Alzheimer's and may display moods/behaviors related to diagnosis such as agitation/aggression. On 3/18/25 at 2:50 PM, V25 (Certified Nursing Assistant/CNA) stated V25 heard a scream from R1. I went to see what was going on. This happened in R2's room. When I went into the room there was a CNA (V26) in the room who was trying to get R1 and R2 apart. R2 was in a wheelchair. R1 was standing. R2 had the wheelchair armrest in hand and was hitting R1 in the head with it. R1 wanders in different resident rooms and is known to lay down in their beds. We have to redirect R1 back into the dayroom. On 3/18/25 at 3:00 PM, V26 (CNA) stated V26 was walking past R2's room and heard R1 saying Stop. I went into the room and saw R2 hitting R1 with an object. R2 did make contact with R1. I immediately called for the nurse. I stood in between them. R2 was in a wheelchair. R1 was standing in R2's room. R1 is a wanderer. I believe R1 went out to the hospital. R2 went out to the hospital and has not been back to the facility. R1 gets confused, tired and wants to sit down. Everybody has the right to wander around. R1 wanders the whole floor. No staff walk with R1. It is typical for R1 to wander into other residents' rooms. R2 is mean and grumpy. R2 has outburst cursing at staff. R1 has dementia. We redirect R1 to the dayroom for monitoring. We (CNAs) take turns in the dayroom. On 3/18/25 at 3:13 PM, V4 (Licensed Practical Nurse/LPN) stated R1 went into R2's room. R1 wanders. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/21/25 at 10:50 AM, V27 (Activity Aide) stated R1 is very sweet. R1 has dementia. R1 walks a lot. R1 goes into other resident rooms. R1 will go into their rooms and talk to them and come out. R1 does not need staff to accompany R1. On 3/21/25 at 11:00 AM, V18 (LPN) stated R1 has dementia, is confused, and talks to herself. R1 is a wanderer and goes into other residents' rooms. R1 does not need staff with R1. Staff need to be aware of where R1 is. R1 can be redirected. Some residents have called to the nursing station saying there is a lady in here (their room). The resident will tell R1 that R1 can't be in there and R1 will walk back out. On 3/21/25 at 11:42 AM, V4 (LPN) stated R1 does not wear an electronic monitor. R1 walks around but does not attempt to leave. The electronic monitor is for residents that try to elope. On 3/21/25 at 12:30 PM, V12 (Licensed Practical Nurse) stated R1 roams a lot, is sweet, and I have not observed any aggressive behaviors. 2.) On 03/18/2025 at 3:05 PM, R5 and multiple other residents sitting in wheelchairs and with walkers observed sitting in the dining room on the second floor of the facility without any staff member inside monitoring the residents in the dining room. On 03/18/2025, at 3:07 PM, surveyor makes V6 (Registered Nurse/RN) aware that residents are inside of the dining room without any staff members monitoring them. V6 states there is supposed to be someone inside of the dining room monitoring the residents at all times. V6 states she is the off-going nurse and there is a change of shift happening. V6 states she is unsure of who is responsible for monitoring the dining room because the CNA assignments have not been made yet by the on-coming nurse. On 03/18/2025, at 3:08 PM, V7 (CNA) was observed walking inside of the second-floor dining room to monitor residents. V7 states she is not aware of who is supposed to be monitoring the residents because the schedule has not been made yet. V7 states she was informed by V6 to monitor the second-floor dining room until a schedule is made. V7 states if residents are not properly monitored, then they can potentially fall and injure themselves, or get into an altercation with one another. On 3/21/25 at 11:43 AM, V17 (Fall Coordinator) states V17 states the CNA staff are responsible for taking turns and monitoring the dining rooms in the facility. V17 states staff monitoring is required in the dining room while residents are present because this can help to prevent falls in the facility. V17 states there should be a staff member monitoring the dining room at all times. V17 states if staff monitoring is not provided to residents, then residents could potentially fall, experience resident on resident abuse, choke, or experience wandering in the facility. 3.) Nursing progress note dated 03/03/2025, at 8:48 AM, documents R4 noted on the floor inside of her room lying on her left side. The resident stated she hit her head and hip and just wants to go home to be with her kids. Vitals stable. ROM (Range of Motion) was assessed. Head to toe and pain assessment completed. Family member, NP/nurse practitioner notified. NP ordered to send R4 to the emergency room for brain scan and x-ray of the hip. Transportation services contacted. Son made aware R4 is going to hospital. (continued on next page)

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	03/25/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/21/2025, at 11:43 AM, V17 (Fall Coordinator) states R4 fell on ce in the facility on 03/03/2025, and she was aware by checking risk management in the electronic health records system. V17 states she does not keep a list of residents who are on fall precautions in the facility. V17 states she does not keep a fall risk precaution/intervention binder or list at the nurses' station for staff reference and knowledge. V17 states residents have a blue dot on their doors, and this represents that the resident is on fall precaution interventions. V17 states staff are made aware of residents who requires fall precautions by observing the blue dot on the residents' door. V17 states she is responsible for updating the residents' care plan whenever a resident falls. V17 states fall precaution interventions should be changed to include a new intervention each time a resident experience a fall in the facility. V17 states after R4 fell in the facility, R4s' care plan should have been updated to reflect that R4 had an actual fall while in the facility. Surveyor deploys R4s' electronic fall care plan interventions on a computer with V17 present. V17 observes interventions are dated 03/18/2025 and signed by V17. Surveyor inquires to V17 why interventions are dated after resident was already discharged from the facility. Surveyor also makes V17 aware that the care plan was signed by herself on 03/18/2025, the same date surveyor began investigations of R4s' fall. V17 states she is not sure why it is dated for 03/18/2025 and signed by herself because she does not remember signing R4s' care plan on 03/18/2025. R4s' fall care plan to reflect V17s' revisions dated 03/18/2025, was requested from V17 on 03/21/2025, at approximately 12:00 PM. This care plan for R4 was not provided to surveyor during this survey. Record review of R4s' care plan does not document that R4 is care planned for having an actual fall on 03/03/2025. Surveyor requested the facility's supervision/monitoring policy and accidents/hazards policy from V2 (Director of Nursing) on 03/18/2025 and 03/19/2025. Facility's supervision/monitoring policy and accidents/hazards policy was not provided to surveyor during this survey. Facility census dated 03/18/2025 documents that a total of 73 residents reside on the second floor of the facility. Facility policy dated 03/17/2025 titled, Baseline Care Plan documents in part, 6. Because the baseline care plan documents the interim approaches for meeting the residents' immediate needs, it should also reflect changes to approaches, as necessary, resulting from significant changes in condition or needs .