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	04/23/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41356 Based on interviews and review of records that facility failed to ensure personal belongings of 1 (R3) out of 3 residents were properly inventoried in accordance with facility's policy. These failures affected 1 resident (R3) resulting in not being able to unable to account personal belonging. Finding includes: R3 is [AGE] years old, initially admitted in the facility on 12/17/2024. R3 medical diagnosis includes amyloidosis, insomnia, anxiety disorder. R3 BIMS (Brief Interview of Mental Status) score dated 03/31/2025 scored at 15 means cognition is intact. On 04/15/2025 at 11:06 AM, R3 stated that his personal belongings that includes pair of headphones, mini wrench with screwdriver, State ID, orange extension cord with USB, titanium phone charging cord. R3 stated that he gave the list to V3 (Social Worker). On 04/16/2025 at 11:14 AM, V3 confirmed that R3 told her about his missing personal belongings. V3 stated that a concern form was done on R3's behalf. V3 stated that R3 should have brought to the receptionist all his belongings upon first arrival in the facility. Because R3 did not bring his belongings to receptionist his personal belongings were not inventoried. V3 stated that R3's belongings list form was not done. V3 was asked if it is the resident's responsibility or facility staff to ensure belongings were accounted to avoid prospective confusion? V3 stated, Here at this facility, we tell them, or the nurse explained to them. V3 was asked if she or any facility staff explained to R3 proper procedure. V3 stated No, I did not ask any of the staff if they did belongings list. We searched for it. All of us helped R3 to find it. We did not find it. On 04/17/2025 at 10:08 AM, V1 (Administrator) was made aware about personal belongings concern of R3. V1 stated that per proper procedure is to fill up belongings list form. And it should be done by staff to account resident's personal belongings. And to avoid future problem when resident will allege that they have certain personal belongings that no one can confirm. Personal Effects policy dated 01/2025, reads: The purpose of inventory is to limit the risk of loss of residents' personal effects and to protect the facility from liability for loss personal effects. The inventory shall be completed upon admission and signed by the resident or resident's responsible party. The inventory shall be updated when items are brought to the facility for the resident or when things are removed from the facility by the resident or resident's responsible party.

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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(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** 41356 Based on observation, interview, and record review the facility failed to accurately assess or evaluate a resident that are high risk for falls, failed to provide plan of care for falls. The facility failed to ensure fall preventive measures or interventions were implemented. The facility also failed to monitor and supervise a resident to prevent falls for 1 (R1) out of 3 residents reviewed for fall prevention program. These failures resulted in R1 falling twice. R1's first fall resulted in R1 being admitted to the hospital with an epidural brain bleed. R1's second fall resulted in R1 sustaining a laceration to the back of his head. Finding includes: R1 is [AGE] years old, readmitted in the facility on 01/07/2025 with repeated falls and traumatic subdural hemorrhage and coagulation defect. Clinical notes of R1 dated 02/03/2025 by V11 (Registered Nurse/RN) documents that R1 was seen on laying on the floor. R1 stated that he hit the back of his head. R1 was transferred to the hospital with admitting diagnosis of epidural brain bleed per V24 (Licensed Practical Nurse/LPN). On 03/18/2025 R1 fell again sustaining a laceration at the back of his head. R1 was transferred to the hospital, currently not in the facility. On 04/16/2025 at 12:09 PM V11 (RN) stated that she worked from 07:00 AM to 03:00 PM the day R1 fell on [DATE]. V11 stated that it was a CNA (Certified Nursing Assistant) that informed her that R1 was on the floor. V11 said, It was an unwitnessed fall. V11 said that R1 does not ambulate, non-compliant to instruction. R1 wants to try to do things that he cannot do. He needs assistance when getting up and needs 1-to-2-person assistance. V11 stated that it was around breakfast time when R1 fell . V11 stated breakfast starts at 07:30 AM and during that time, R1 ate breakfast in bed. V11 stated that she did not see anyone feed R1. V11 was asked if it would be safer for R1 to be transferred to the wheelchair and monitor by staff instead of leaving R1 in his room alone. V11 stated I am not sure if it will prevent R1 from falling. V11 stated that R1 was not transferred to his wheelchair because he is not on the get up list. V11 stated it would be hard for CNAs who are busy feeding another resident to come wash up R1 and place R1 in a wheelchair. (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 - Actual harm Residents Affected - Few	On 04/16/2025 at 1:52 PM, V2 (Director of Nursing/DON) stated R1 kept saying he can walk, and he tries to maintain his independence. R1 was not on the get up list and was not scheduled to get up. Reviewed R1's care plan with V2. R1's fall care plan does not have any fall prevention interventions prior to the fall and was created on 02/03/2025. R1's fall care plan interventions are as follows: Encourage R1 to ask for assistance before transferring created on 2/11/2025, floor mat in place created date 03/18/2025, R1 will receive education related to potential fall risk and preventative measures created 02/10/2025. Per statement by nursing staff, R1 is non-compliant with instruction. R1 insist he can walk does not follow redirection. V2 was asked, how can these interventions help prevent R1 from falling? V2 stated the problem was that he got up without assistance. V2 was asked about the investigation she conducted. V2 was asked if the nursing staff, both nurses, and certified nursing assistants' whereabouts were accounted for. V2 replied, In doing our investigation we don't asked nursing staff where they are at the time of the fall or during the fall. V22 (CNA) that was assigned to R1 does not have written statement as part of investigation. V2 was informed that R1 fell again inside his room on 03/18/2025 sustaining laceration on the back of his head with bleeding. V2 replied, I have to look at the records. V2 stated that other interventions can prevent fall of R1, like putting signage or placing R1 in the get up list. On 04/22/2025 at 11:38 AM V7 (LPN) verified that she was the nurse on the day R1 fell on [DATE]. V7 stated that R1 was trying to get in his wheelchair when he fell . V7 stated that none of the staff was in the room. None of the staff witnessed the fall of R1. R1 had bleeding on the middle area of his head. V7 stated it happened around 08:00 PM as it was noted in her notes. R1's assessment for admitted d 01/07/2025 and re-admitted d 02/17/2025 documents that R1 is at high risk for fall with score of 16 on 01/07/2025. R1's score increased to 20 on 02/17/2025. Per assessment instructions, any score above 10 considered as high risk for falls. Although both assessments have scores higher than 10, staff who assessed put the score of 8 on both assessments indicating that R1 is not high fall risk. There was no baseline care plan intervention provided on both assessments. On 04/22/2025 at 10:18 AM, reviewed R1 fall assessments, evaluations and fall care plans with V25 (Restorative Nurse/LPN) and V26 (Restorative Nurse/LPN). V25 stated that the number or score is wrong on R1's fall assessment included during admission evaluation dated 01/07/2025 (prior to fall) and 02/17/2025 (after to fall). V25 stated that the score eight (8) represent the number of items being answered, not the score based on fall assessment. Per fall assessment ten (10) and above means high risk of fall. R1's score should be sixteen (16) for the assessment dated [DATE] which is a high risk of fall. R1's score for the fall assessment dated [DATE] should have been scored 20 which is high risk for fall. V25 was made aware that there was no baseline plan of care intervention for all fall assessments of R1. Upon reviewing the care plan, V25 stated that R1 does not have any fall care plan prior to fall. V25 said, Nothing on 01/07/2025 care plan for fall. V25 and V26 made aware on their policy fall assessment/evaluation and fall care plan review should be done during admission and quarterly to prevent resident from falling. R1 does not have fall interventions upon admitted d 01/07/2025 although he came in the facility with history of falls. On 04/23/2025 at 09:44 AM, V2 (Director of Nursing) was made aware of concerns related to R1 fall assessments/evaluations and lack of care plan interventions prior to falls. V2 stated that it will help prevent fall for R1 if there were interventions placed prior to the falls. V2 said, I cannot say that all falls can be prevented. But interventions prior to fall may help prevent falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Fall Prevention and Management policy dated 02/2025 reads: This facility is committed to maximizing each resident's physical, mental and psychosocial well-being. The facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible. All resident falls shall be reviewed, and the resident's existing plan of care shall be evaluated and modified as needed. All fall risk evaluation will be completed on admission, readmission, and quarterly, significant change and after each fall. A fall risk evaluation is completed by the Nurse. A score of 10 or greater indicates the resident is at high risk for falls; a score of less than 10 indicates at risk for fall. Care plan to be updated with new intervention based on root cause analysis after each fall occurrence.