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	05/07/2025

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 0686 Level of Harm - 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** 50662 Based on interview and record review the facility failed to assure that a resident (R1) with pressure ulcers received the necessary treatment and services to promote wound healing. This failure caused one resident's (R1) wound to decline leading to wound infection and hospitalization . Findings include: R1's medical diagnoses include but are not limited to displaced fracture of lesser trochanter of right femur, muscle weakness, cognitive communication deficit, type 2 diabetes mellitus, pressure ulcer of unspecified heel unspecified stage, pressure ulcer of sacral region stage 3, acute diastolic heart failure. R1's Minimum Data Set (MDS) dated [DATE] has a Brief Interview for Mental Status score of 9, which indicates R1's cognition is moderately impaired. R1 admission progress note dated 02/06/25 at 9:32pm documents in part, has wound on the coccyx, right and left lateral heel. R1's care plan dated 02/06/25 documents in part, R1 was admitted with skin alterations and is at risk for further breakdown related to fragile skin, friction, decreased sensory awareness, impaired mobility and a past medical history that includes hypertension .infection will not develop at the wound site. Review of R1's records show no wound assessment or wound care orders until 02/14/25. R1's progress note dated 02/14/25 documents in part, Writer alerted that patient has alterations to skin, assessment performed, patient noted with open areas to his sacrum, right heel and a DTI (Deep Tissue Injury) on his left heel. MD (Medical Doctor) notified, verbal treatment orders received, carried out, and tolerated well by patient. R1's wound culture with collection date of 02/19/25 documents in part, culture wound - sacrum .gram stain: few gram-negative bacilli .few gram-positive cocci .rare white blood cells .rare epithelial cells .mixed gram-negative bacilli also present .methicillin resistant staphylococcus aureus few. R1's physician order dated 02/19/25 documents in part, Bactrim DS oral tablet 800-160 mg (milligrams) .give 1 tablet by mouth every 12 hours for wound infection for 5 days until finished. (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

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 0686 Level of Harm - Actual harm Residents Affected - Few	R1's wound physician assessment dated [DATE] documents in part, wound size 9 by 9 by 0.5 cm (centimeters) .periwound radius odor .exudate moderate purulent .thick adherent devitalized necrotic tissue 80% .wound progress exacerbated due to infection. R1's progress note dated 02/23/25 at 12:10pm documents in part, Noted to have altered mental status, lethargy, O2 (oxygen) saturation low 83% room air with nrb (non-rebreather) mask 15lnc (liter per nasal canula) stared O2 saturation 95%, BP (blood pressure) low with shortness of breath, diaphoretic. No fever at this time. V12 (Medical Doctor) called with order for hospital transfer stat. 911 paramedic called. R1's progress note dated 02/23/25 at 4:20pm documents in part, admitted at hospital with diagnosis of sepsis. R1's hospital records dated 02/23/25 documents in part, acute metabolic encephalopathy likely due to sepsis from sacral wound infection .sepsis due to sacral ulcer .consult wound and surgery. On 05/05/25 at 2:24pm V18 (Wound Care Nurse/Licensed Practical Nurse) stated that the facility did not have a wound care nurse for approximately one week. V18 stated that R1 was not assessed by wound care until 02/14/25. V18 stated that R1 did not have wound care orders until 02/14/25. V18 stated that if wounds are not treated then they could decline and become infected. On 05/06/25 at 12:19pm V12 (Medical Doctor/MD) stated that R1's wounds had previously been stable. V12 stated that it is possible that if the facility did not take care of R1's wounds, that could be part of R1's decline in condition. On 05/06/25 at 1:06pm V15 (Wound Care MD) stated that a resident should have wound care orders continued from the discharging hospital until she assesses them. V15 stated that if wounds are not treated then the wounds can deteriorate. On 05/06/25 at 2:34pm V2 (Director of Nursing) stated that if a resident doesn't have wound orders, then the nurse should get wound orders from the doctor. V2 stated that she was unaware that R1 did not have wound orders from 02/06/25 until 02/14/25. V2 stated that R1 not having wound orders is not acceptable practice and he should have orders, so the wound doesn't get worse. Facility's policy titled Skin Management: Monitoring of Wounds and Documentation dated 01/2023 documents in part, General: 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. Facility's policy titled Residents' Rights dated 11/2018 documents in part, Your rights to safety .Your facility must provide services to keep your physical and mental health, at their highest practical levels.