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	08/27/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to ensure staff monitor a resident's blood glucose per physician's order and failed to ensure staff document the result of the blood glucose accordingly. These failures affected 1 (R67) resident reviewed for professional standard of care in the total sample of 66 residents.Findings include:On 08/25/2025 at 8:57am, V22 (Licensed Practice Nurse) opened R67's electronic health record, the 7:30am glucose check was red and read as blood glucose before meals and before bedtime. V22 stated the facility serves breakfast on the first floor between 8:00am to 8:30am. On 08/25/2025 at 8:59am, V30 (Certified Nursing Assistant) was assisting R67 with feeding. R67's food tray was almost empty except for the cookie. V30 stated she (R67) still wants her cookie. On 08/25/2025 at 9:00am, V22 took R67's blood sugar; the glucometer announced the result as 309. On 08/25/2025 at 9:01am, V22 stated he was supposed to take her blood sugar before breakfast. Review of R67's (08/2025) MAR (Medication Administration Record documented, in part Blood glucose via Accuchecks before meal and at HS (hour of sleep) for diabetes. 08/25, 730(7:30am), 144. 1100 (11:00am), 131. Signed by V22 (Licensed Practice Nurse).On 08/26/2025 at 9:54am with V2 (Director of Nursing), V30 stated that she was present when V22 took her (R67)'s blood sugar on 08/25/2025 at around 9am and the result was at 300 or something.On 08/26/2025 at 11:41am, V2 (Director of Nursing) stated the expectation is to get the blood sugar before breakfast. At this time, this surveyor presented V2 the 1st floor mealtimes. V2 stated staff is expected to get the blood sugar between 7:00am and 7:15am to prevent from getting a false reading. I also expected the nurse (V22) to document the accurate result, if it is 200 then document 200. Documenting the correct result will determine the resident's endocrine system is working or an adjustment to her diabetes medications need to be done. On 08/27/2025 at 10:04am, V50 (Nurse Practitioner) stated blood glucose monitoring is usually ordered to make sure the resident's diabetes is well controlled. The staff are expected to document the correct result so when the physician reviews the results, the physician will be able to determine whether the medication is working appropriately or needs to be adjusted. The expectation is to follow the physician's order to get the blood sugar; it is usually before meals and before bedtime.R67's (Active Order as of: 08/25/2025) Order Summary Report documented, in part Diagnoses: (include but not limited to) hypertension, chronic pain, and Type 2 Diabetes Mellitus. Order Summary: Blood Glucose via Accuchecks before meals and at bedtime for Diabetes. Order date: 07/30/2025.R67's (08/2025) MAR (Medication Administration Record documented, in part Blood glucose via Accuchecks before meal and at HS (hour of sleep) for diabetes. 08/25, 730(7:30am), 144. 1100 (11:00am), 131. Signed by V22 (Licensed Practice Nurse). The (undated) Mealtimes 1st Floor Dining Area documented in part Breakfast: 7:15am.The (01/01/2025) Blood Glucose Monitoring documented, in part Policy: It is the policy of this facility to perform blood glucose monitoring to a diabetic residents as per physician's order. Policy Explanation and Compliance Guidelines: 1. The facility will perform blood glucose monitoring per physician's orders. Procedure: 21. Document the procedure.

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 Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to assure that one resident (R7) with intact skin, received the necessary treatment and services to prevent the development pressure wounds. This failure resulted in R7's development and worsening of one pressure ulcer, requiring hospitalization for wound infection and surgical intervention of wound. The facility failed to ensure one resident's (R77) low air loss mattress was set at the correct settings. These failures affected two residents (R7 and R77) in a total sample size of 66. Findings include: 1.) On 08/24/2025 at 11:48am, R77 was lying on a low air loss mattress; setting was at 280lbs. This observation was pointed out to V12 (Registered Nurse/RN). V12 stated low air loss mattress should be set based on the resident's weight to promote healing. If the setting is higher than the resident’s weight, the surface will be hard, and it will impair with the healing process of the wound. On 08/26/2025 at 10:58am, V31 (Wound Care Nurse/Licensed Practical Nurse) stated the setting of the low air loss mattress should be based on the resident’s weight. If the weight falls between a range. Then the setting should be on the lower side of the range. The purpose of the low air loss mattress is for prevention and treatment of wounds. When the setting is above the weight of the resident, low air loss mattress creates a hard surface. A hard surface defeats the purpose of the low air loss mattress. R77’s (Active Order as of: 08/25/2025) Order Summary Report documented, in part “Diagnoses: (include but not limited to) quadriplegia, pressure ulcer of sacral region, pressure ulcer of left and right ankle, and pressure ulcer of other site. Order Summary: Skin. Pressure redistribution mattress. Order Date: 02/25/2025.” R77’s (printed: 08/24/2025) Weight and Vital summary documented, in part “08/05/2025: 116lbs.” R77’s (06/03/2025) Minimum Data Set documented, in part “Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 06.” Indicating R77’s mental status as severely impaired. “Section M. Skin Conditions. M0150. Risk of Pressure Ulcers/Injuries: 1 – yes. M1200. Skin and Ulcer /Injury Treatments: B. Pressure reducing device for bed.” R77’s (05/06/2025) care plan documented, in part “risk for alteration in skin integrity. Interventions: Pressure redistribution mattress (LAL - Low air loss mattress). The Operation Manual documented, in part “The (Brand name) pump and overlay system is indicated for the prevention and treatment of any and all stage pressure ulcers when used in conjunction with a comprehensive ulcer management program. Pressure-adjust Knob. Determine the patient’s weight and set the control know to that weight setting on the control unit. Operating Instruction. Step 6. Determine the patient’s weight and set the control knob to that weight setting on the control unit. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	2.) R7’s medical diagnoses include but are not limited to type 2 diabetes mellitus, diastolic congestive heart failure, essential hypertension, benign neoplasm of right breast, acute kidney failure. R7’s Minimum Data Set (MDS) dated [DATE] has a Brief Interview for Mental Status score of 13, indicating R7’s cognition is intact. R7’s MDS dated [DATE] section M’s Determination of Pressure Ulcer/Injury Risk documents in part, “A. Resident has a pressure ulcer/injury, a scare over bony prominence, or a non-removable dressing/device…No….Is this resident at risk of developing pressure ulcers/injuries? .Yes” R7’s care plan with initiation date of 08/13/24 and revision date of 04/25/25 documents in part, “R7 has potential/ at risk for alteration in skin integrity due to risk factors associated with fragile skin, friction, immobility, decreased sensory awareness, presence of cardiac pacemaker, a PMHx (past medical history) that includes breast CA (cancer), hemiplegia, hemiparesis….Decrease/minimize risk for skin breakdown…skin checks by CNA (Certified Nursing Assistant) and floor nurse on bath/shower days paying particular attention to bony prominences, if impairment is present, follow appropriate skin impairment protocols…pressure redistribution mattress…remind/assist resident to reposition frequently. ” On 08/24/25 at 12:01pm R7 stated that she did not have any wounds when she first arrived at the facility. R7 stated that she developed the wound on her sacrum area at the facility. R7 stated that the facility’s staff does not clean and reposition her as needed. On 08/25/25 at 12:15pm V31 (Wound Care Nurse/Licensed Practical Nurse) stated that R7 did not have a wound when R7 arrived at the facility. V31 stated that R7’s wound to R7’s sacral region was facility acquired on 05/29/25. R7’s progress note dated 05/29/25 documents in part, “R7 is chairfast, incontinent of B&B (bowel and bladder), and totally dependent for ADL’s (Activities of Daily Living). Staff alerted the wound care team about a skin alteration on the patient’s right buttock, assessment performed, patient noted with MASD (moisture associated skin dermatitis)…Wound care will continue to monitor and treat the wound.” Review of R7’s records show no documentation or indication that R7’s new wound to sacral area was unavoidable. R7’s wound assessment dated [DATE] documents in part, “Wound #1 Sacral is an acute Unstageable Pressure Injury Obscured full-thickness skin and tissue loss Pressure Ulcer acquired on 05/29/2025 and has received a status of Not Healed. Initial wound encounter measurements are 6.8cm length x 6.8cm (centimeter) width x 0.1 cm depth, with an area of 46.24 sq (square) cm and a volume of 4. 624 cubic cm. No tunneling has been noted. No sinus tract has been noted. No undermining has been noted…76-100% adherent, yellow slough.” (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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 08/26/25 at 2:55pm V2 (Director of Nursing/DON) stated that she assessed R7 the day R7 was sent to the hospital. V2 stated that R7 appeared lethargic and kept moaning “it hurt, it hurt”. V2 stated that she instructed the nurse to call the doctor for orders to send R7 out to the hospital. R7’s progress note dated 06/07/25 documents in part, “NP (nurse practitioner) making rounds with writer, observed resident lethargic with altered mental status, unstable vital signs…received order to send resident out 911.” R7’s hospital discharge records dated 06/16/25 documents in part, “patient was admitted for workup of AMS (altered mental status) and hypotension…Infectious workup remarkable for Bacteroides fragilis. CT (Computed Tomography) pelvis showing sacral decubitus ulcer with osseous destruction of the lower sacrum/coccyx suggestive of osteomyelitis. ID (Infectious Disease) consulted, recommended IV (Intravenous) CTX (Ceftriaxone) and Flagyl with plan to transition to Augmentin at discharge…Plastics was consulted due to concern for sacral wound being source of infection….Attempted minor debridement x2 but patient couldn’t tolerate due to pain.” R7’s progress note dated 06/17/25 documents in part, “R7 is chairfast, incontinent of bowel and bladder and requires extensive assistance transferring and completing ADL’s…wound to sacrum noted as unstageable with palpable bone.” R7’s wound assessment dated [DATE] documents in part, “clinical stage: unstageable…Measurements: size (cm) centimeters: 9.00x10.00x1.10 (L x W x D) Length times width times depth.” On 08/26/25 at 11:01am V31 (Wound Care Nurse/Licensed Practical Nurse) stated that she assessed R7’s wound upon readmission from the hospital. V31 stated that R7’s sacral wound had bone exposed. V31 stated that R7 was in a lot of pain with wound care dressing changes. V31 stated that R7 has always been compliant and has never refused care. R7’s MDS dated [DATE] section M’s Determination of Pressure Ulcer/Injury Risk documents in part, “A. Resident has a pressure ulcer/injury, a scare over bony prominence, or a non-removable dressing/device…Yes…F1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar…1.” Facility’s policy titled “Skin Care Prevention” dated 01/2025 documents in part, “General: All residents will receive appropriate care to decrease the risk of skin breakdown. Responsible Party: All Nursing Staff. Guideline: 1. The nursing department will review all new admissions/readmissions to put a plan in place for prevention based on the resident’s activity level, comorbidities, mental status, risk assessment and other pertinent information. 2. Dependent residents will be assessed during care for any changes in skin condition including redness and this will be reported to the nurse. The nurse is responsible for alerting the Health Care Provider. 3. All residents will be evaluated for changes in their skin condition… 5. All residents unable to reposition themselves will be repositioned as needed, based on a person-centered approach (minimum of every 2 hours).” (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Facility’s policy titled “Residents’ Rights” dated 11/2018 documents in part, “As a long-term care resident in Illinois, you are guaranteed certain rights, protections and privileges according to state and federal laws…Your rights to dignity and respect…Your facility must provide equal access to quality care regardless of diagnosis, condition, or payment source…Your rights to safety…Your facility must provide services to keep your physical and mental health, at their highest practical levels.” Facility’s undated job description titled “Wound Care Nurse” documents in part, “Basic Function: The primary purpose of Wound Care Nurse is to provide for the day-to-day care needs of the residents in a Skilled Nursing Facility Environment…Essential Duties:…2. Must be able to identify changes in the resident condition and evaluate the resident care needs…17.Recognize significant changes in the condition of residents and take necessary action.”