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	09/25/2024

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 41611 Based on observation, interview and record review, the facility failed to assess a resident's ability to safely self-administer medications which affected one resident (R155) when reviewed for self-administration of medications in the total sample of 65 residents. Findings include: R155 has a diagnosis of but not limited to Multiple Subsegmental Thrombotic Pulmonary Emboli, Type 2 Diabetes Mellitus with other Circulatory Complications, and Asthma. R155 has a Brief Interview of Mental Status score of 15. On 9/22/2024 at 10:45am surveyor observed a red inhaler on R155's over-the-bed table. R155 said, Yes, I do have asthma, but I really don't use that inhaler. On 9/22/2024 at 11:32am via email V2 (Director of Nursing/DON) said Leaving an inhaler at the bedside of a resident who does not have a medical order or has not received proper education on its use can lead to several potential harms and risks. The resident may attempt to use the inhaler without knowing the correct technique. Inhalers require specific coordination between inhaling and pressing the canister, which, if done incorrectly, can lead to ineffective treatment or respiratory distress. If the residents are unaware of how often they should use the inhaler, they may overuse it, leading to side effects such as increased heart rate, dizziness, or shaking. On the other hand, improper or infrequent use could prevent them from getting the full benefit of the medication, potentially worsening their condition. Inhalers are meant for individual use. If another resident uses the inhaler, it can lead to the transmission of infections, particularly respiratory illnesses, which can be dangerous in healthcare settings. On 9/22/2024 at 2:17pm V2 (DON) stated that a resident can self-administrate their meds if they have an order and have received education on how to self-administrate the medicine from a Registered Nurse. On 9/23/2024 at 2:30pm surveyor reviewed R155's electronic medical record and did not find a Medication Self-Evaluation Form. R155's Order Summary Report with active orders as of 9/24/2024 does not document an order for an Albuterol Asthma Inhaler. (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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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress note dated 9/24/2024 at 2:46am documents I only had my asthma pump because the surgeon told me to bring it and I gave it back to my nurse on Sunday. Policy titled Self Administration of Medications and Treatments with a review date of 1/2024 documents, in part, self-administration of medications and treatments is determined by an order after determining that the resident is able to self-administer and determination of the ability to self-administer medications will be done by nursing using the form in PCC (Point Click Care) titled Medication Self-Evaluation Administration and resident teaching will be performed by nursing staff.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 49572 Based on observation, interview, and record review, the facility failed to ensure that call lights were within reach for 3 residents (R15, R72 and R120) and failed to ensure linen was provided for one resident (R124). This failure had the potential to affect 4 residents out of a sample of 65 residents reviewed for reasonable accommodation of needs. Findings include: 1.) On 9/22/24 at 10:58am, this surveyor observed R124 lying in bed, on his left side, on a bare mattress with no linen on the mattress or a blanket. This surveyor inquired about R124 having no linen for the mattress and no blanket. R124 replied, They (staff) said they don't have any. This surveyor inquired to R124 about R124's preference for linen and a blanket. R124 replied, Of course I (R124) want sheets on my mattress. My skin sticks to this plastic mattress. It's annoying. Or at least a blanket. It can get a little cold sometimes. R124's Face sheet, documents, in part, medical diagnosis including but not limited to type 2 diabetes mellitus, schizophrenia, major depressive disorder and unspecified abnormalities of gait and mobility. R124's Brief Interview of Mental Status (BIMS) score, dated, 7/02/24, documents, in part, a BIMs score of 13 which indicates R124 is cognitively intact. 2.) On 9/22/24 at 11:04am, R72 was observed in his room, lying on his back in bed. When asked if R72 can reach his call light, R72 replied, I (R72) don't even know where it is. I (R72) usually ask one of my roommates to get the nurse because I (R72) can never find the call light. R72's Face sheet, documents, in part, medical diagnosis including but not limited to chronic obstructive pulmonary disease, unspecified, chronic embolism and thrombosis of deep veins of lower extremity, seizures, and morbid (severe) obesity due to excess calories. R72's Brief Interview of Mental Status (BIMS) score, dated, 6/19/24, documents, in part, a BIMs score of 13 which indicates R72's is cognitively intact. R72's Care Plan, revision date 11/27/23, documents, in part, Falls . Have commonly used items within reach. R72's Care Plan, revision date 4/24/23, documents, in part, (R72) has an ADL (Activities of Daily Living) Self Care Performance . Transfer: The resident requires limited assistance x1 staff participation to CNA (certified nursing assistant). Personal Hygiene/Oral Care: The resident requires extensive assistance x1 CNA staff participation with personal hygiene and oral care. Dressing: The resident requires extensive assistance x1 staff participation to dress. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.) On 9/22/24 at 11:08am, R15 was observed lying in bed, on his back and R15's call light was under his bed not within reach. R15 said, I (R15) can't do much for myself anymore. I (R15) need these people help a lot here. This surveyor asked R15 if R15 knew where his call light was located and R15 replied, I've (R15) been looking for it for a while. I (R15) just can't seem to find to it. R15's Face sheet, documents, in part, medical diagnosis including but not limited to ataxia following other cerebrovascular disease, nontraumatic intracerebral hemorrhage, unspecified, epilepsy, unspecified, not intractable, without status epilepticus, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, altered mental status, unspecified, other abnormalities of gait and mobility, other lack of coordination, cognitive communication deficit and hemiplegia, unspecified affecting left nondominant side. R15's Brief Interview of Mental Status (BIMS) score, dated, 8/14/24, documents, in part, a BIMs score of 06 which indicates R15's cognition is severely impaired. R15's Care Plan, revision date 8/9/24, documents, in part, Fall: (R15) is at risk for falls Cognitive deficits, Functional Deficits. Encourage appropriate use of Assistive Device. 4.) On 9/22/24 at 11:10am, R120 was observed in bed, lying on his right side and R120's call light was under his bed not within reach of R120. This surveyor asked R120 if R120 could locate his call light and R120 replied, Probably on the floor again where I can't reach it. I do need to find that sucker because I need these nurses' help. R120's Face sheet, documents, in part, medical diagnosis including but not limited to cerebral infarction, unspecified muscle weakness (generalized), unsteadiness on feet and other abnormalities of gait and mobility. R120's Brief Interview of Mental Status (BIMS) score, dated, 8/6/24, documents, in part, a BIMs score of 14 which indicates R120 is cognitively intact. R120's Care Plan, revision date 4/24/24, documents, in part, Transferring: (R120) has a self-care deficit in transferring r/t (related to) weakness. On 9/22/24 at 11:12am, while in R120's and R15's room, V6 (Certified Nursing Assistant/CNA) said, R120's call light cord is tangled behind his refrigerator and the call light is under his (R120) bed. This surveyor inquired about the location of both R15's and R120's call lights and V6 replied, They both cannot reach their call lights. The call lights should be attached to their pillow so they can reach it to call for help. On 9/22/24 at 11:17 am, while in R72's room, V7 (Registered Nurse/RN) said, R72's call light must have fell on the floor. No, R72 can't reach it. I'll clip it next to him so he can reach it and call us. On 9/22/24 at 11:25am, while in R124's bedroom, V7 (RN) stated, The CNA needs to put a sheet on R124's bed. We have sheets. I'll let them know. It's probably not comfortable for him (R124) without the sheet. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/23/24 at 12:16pm, while in R124's room with V7 (RN), R124 was observed, again, lying in bed, on a bare mattress with no linen on the mattress or a blanket. V7 said, I told the CNA yesterday to put a sheet on R124's bed. Let me see what's going on with this. I'll just do it myself. On 9/24/24 at 2:12pm, V2 (Director of Nursing) said, I expect call lights to be answered in a timely manner and immediately. Call lights should be accessible to the resident, pinned to the bed within reach. On 9/25/24 at 11:08am, V2's e-mail documents, in part, Linen is provided daily as needed, linen is changed on shower day, and PRN, All residents should have linen, and blankets if they prefer. Facility policy titled, Call Light Response, reviewed date 1/10/24, documents, in part, . 3. Ensure the call light is always within the resident's reach. 4. When the patient or resident is in bed or confined to a bed or chair, provide the call light within easy reach of the patient or resident. Facility presented document titled, RESIDENTS' RIGHTS for People in Long-Term Care Facilities, revision date 11/2018, documents, in part, Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must provide services to keep your physical and mental health, at their highest practical levels.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 50728 Based on observation, interview and record review, the facility failed to ensure state survey records were kept publicly for residents to review. This failure has the potential to affect all 223 residents in the facility. Findings include: Record review of facility census documents in part that 223 residents reside within the facility. On 9/23/24 at 10:37 AM, resident council meeting was conducted. R29 (resident council president) affirmed that state inspections were not available for residents to read. On 9/23/24 at 12:46 PM, V1 (Administrator) stated that V1 did not know where the survey findings were kept and that V1 would have to ask V24 (Assistant Administrator/Social Worker). On 9/23/24 at 12:48 PM, V1 stated that the results are kept on the table by the entrance to the front door. V1 observed the table, and no survey records were located. V1 stated, I don't know where they (survey records) are, they should be here. V1 affirmed that it is important for records to be able to be viewed by residents because residents have the right to view survey records. On 9/24/24 at 3:56 PM, surveyor observed table by the entrance where survey records were to be kept, and no survey records were noted. Review of facility provided document titled, Residents' Rights for People in Long-Term Care Facilities (undated) documents in part, . You (Resident) have the right to see reports of all inspections by the Illinois Department of Public Health from the last 5 years and the most recent review of your facility along with any plan that your facility gave to the surveyors saying how your facility plans to correct the problem .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41611 Based on observation, interview, and record review the facility failed to document the code status for one resident (R213). This failure affected one resident (R213) in the sample size of 65. Findings include: R213 has a diagnosis of but not limited to Metabolic Encephalopathy, Sepsis, Hypocalcemia and Acidosis. On [DATE] at 12:36pm surveyor reviewed R213's profile screen and there was no code status listed and in the orders section there were no order for Advance Directive (code status) in electronic medical record. R213's Orders Summary Report with Active Orders As of [DATE] documents, in part, an order for Advance Directive Code Status dated [DATE]. R213's Practitioner Order For Life-Sustaining Treatment (POLST) Form documents, in part, Attempt Resuscitation/CPR and has a date of [DATE]. On [DATE] at 10:27am V34 (Registered Nurse) stated a resident's code status should appear on the face sheet and on the profile screen in the electronic medical record. On [DATE] at 2:17pm V2 (Director of Nursing) stated a resident's code status is supposed to be put in the electronic medical record upon admission on the profile screen and there should be an order also. Policy titled Advance Directives and DNR with a revised date of [DATE] documents, in part, it is the policy of this facility to follow an individual 's physician order and a Full Code order will be noted in the resident's medical record.

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). 49572 Based on observation, interview, and record review the facility failed to consistently ensure that one resident (R72) was not confined to his room as evidenced by observations of one resident without documented interventions and R72 verbalizing not getting out of his room. This failure resulted in R72 stating R72 feels like R72 is in a prison and is getting worse. This failure affected one resident (R72) reviewed for involuntary seclusion in a sample of 65 residents. Findings include: On 9/22/24 at 11:04am, R72 was observed in his room, lying on his back in bed, with a nasal cannula in his nose at 2 liters of oxygen. R72 stated, I have been here awhile. It wouldn't be too bad here if they (staff) would help me get out of bed and out of this room. If I could do it myself I would, but I can't. I feel like I'm in prison. This is not a way to live. I'm not getting better here. I'm getting worse. My a** hurts all day. I can't get off this oxygen cause all I do is lay in bed. The only person I talk to is my wife when she visits me. You see this curtain (R72 pointed to the privacy curtain encircling his bed)? That's what I look at all day. I can't even go home for a few days cause of this d*** oxygen. They (staff) never get me up. When asked if R72 refuses care and refuses to get up, R72 replied, I never refuse to get up. I beg them to get me up and out of this room. I will ask the staff to get me up and they would just say, I'll be back later and never come back. Or not today, I'm too busy. I've refused to get my labs done but never to get out of this bed and out of this room. Can you please help me with that? R72's Face sheet, documents, in part, medical diagnosis including but not limited to chronic obstructive pulmonary disease, unspecified, chronic embolism and thrombosis of deep veins of lower extremity, seizures, and morbid (severe) obesity due to excess calories. R72's Brief Interview of Mental Status (BIMS) score, dated 6/18/24, documents, in part, a BIMs score of 13 which indicates R72 is cognitively intact. R72's Care Plan, revision date 9/10/24, documents, in part, (R72) is an adult living with chronic health conditions and co-morbidities that requires the support, services and structure of this care setting to maintain stability and highest practicable level of functioning. (R72) will be treated with respect, dignity and reside in the facility free of mistreatment (i.e.: abuse/neglect) . R72's Care Plan for Psychosocial Wellbeing, revision date 6/5/24, documents in part, (R72) demonstrates significant mood distress related to: difficult time adjusting to losses of independence and placement in facility and changes in roles/status, feeling guilty and out of control (powerless, hopeless, incomplete, incompetent), remaining secluded in his room for the majority of the day. R72's Care Plan, revision date 8/14/23, document in part, (R72) has Oxygen Therapy r/t (related to) dx (diagnosis) of COPD (chronic obstructive pulmonary disease) .Encourage or assist with ambulation as indicated. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R72's Care Plan, revision date 4/1/23, document in part, (R72) functioning at a reasonably independent level concerning leisure pursuits. Introduce the resident to peers with similar interest. On 9/22/24 at 11:17am, while in R72's room, when this surveyor inquired about R72 getting out of bed and out of his room V7 (Registered Nurse/RN) replied, We (staff) sometimes get R72 out of bed. He gets out every now and then. I'm not sure how often. R72 doesn't want to get up sometimes. Sometimes he refuses. R72 heard V7 say sometimes he refuses, and R72 interrupted and said, That is not true. I (R72) always want to get up. I want to get up now. You guys (staff) say you're either too busy or you will later but never do. Ya'll never get me up. I (R72) never refuse to get out of this room. When asked when the last time R72 had gotten out of bed and out of his room V7 replied, I'm not sure. When asked if R72 had gotten up and out of his room any time last week V7 replied, Don't know. On 9/23/24 at 12:10pm, R72 was observed in the dayroom, sitting up in the chair working on a crossword puzzle. R72 said, Thank you for getting them to help me finally. This isn't like home but it's better than lying in bed all day. On 9/24/2024 at 10:00am, this surveyor requested documentation from V2 (Director of Nursing) showing that R72 has been getting out of bed and out of his room. On 9/24/24 at 11:46am, V45 (Director of Therapy) said, Occupational therapy was seeing R72. The last time occupational therapy seen R72 was 6/20/23, because (R72) was discharged from occupational therapy because (R72) reached the maximum potential achieved. R72 was then referred to Restorative Nursing and has been seeing Restorative Nursing ever since. R72 had 6 visits with us (occupational therapy), and it appears that during the visits he (R72) did not leave his room. Occupational Therapy did left hand grip exercises, weight shifting on the bed .oh looks like on 6/21/23, R72 did a pivot transfer most like from the bed to commode in his room. R72's Order Summary Report, dated 9/3/24, documents, in part, OT (Occupational Therapy). Clarification orders: 3/wk. for 4 weeks for AOL training (assurance of learning), NM (neuromuscular) reeducation, therapeutic activities, therapeutic exercises . Active . Order date 6/20/23. R72's Order Summary Report, dated 9/3/24, documents, in part, OT Clarification orders: 3/wk. for 4 weeks for AOL (assurance of learning) training, therapeutic activities, therapeutic exercises, NM (neuromuscular) reeducation . Active . Order date 4/04/23. R72's Order Summary Report, dated 9/3/24, documents, in part, PT (Physical therapy)-Continue with PT 3x/week for 2 weeks to address Phone therapeutic activities, NMR (neuromuscular reeducation), therapeutic exercise, gait training, group and wheelchair management, effective 4/19/23. On 9/24/24 at 12:38pm, V47 (Nurse Practitioner) said, I'm familiar with R72 . When asked about R72's mobility status and ADLs (activities of daily living) V47 replied, He's (R72) heavier set; harder to get up; up with assist, 2 people (staff) I believe. The times that I saw R72 he was always in his room. R72 has no restriction to get up and get out of bed. Yes, (R72) can leave his room. When asked about R72's medical and mental status due to remaining in bed and not getting up and out of his room, V47 replied, R72's medical status is worsening due to staying in bed most of the time. It slows down his GI (gastrointestinal) motility, respiratory status, yeah . (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/24/24 at 1:27 pm, V49 (Restorative Nurse) said, I'm familiar with R72. I (V49) think he's on oxygen. Big guy. I don't not know his restorative programs off hand. I see people every 3 months, quarterly and at discharge. I make the programs for the residents and the Restorative Aide do the programs with residents. I do not chart it in the computer. I have a sticky note on a wall in my office that shows who needs what done and it gets checked off when done. I keep them (sticky notes) up there just a few months. On 9/24/24 at 1:40pm, V48 (Nurse Practitioner) said, Yes, I'm familiar with R72. He's (R72) morbid obese, big COPD (chronic obstructive pulmonary disease), on oxygen and we're trying to get the swelling down in legs and lose weight. I've been seeing him a year .more than a year. No, I haven't seen him out of his room, or in a chair. He usually stays in room. When asked if R72's limited time out of bed and out of his room is causing harm to R72's physical and mental health, V48 replied, Of course. Think about it. For COPD, getting out of bed is the first line of defense. Lying in bed and having his weight pressed on his lungs is preventing his lungs from fully expanding and getting off the oxygen. It's definitely affecting his mental health as well. On 9/24/24 at 2:03pm, V52 (Restorative Aide) stated that she has been working with R72 since May or June of this of 2024. V52 said, He's just been on active range of motion, dressing and bed mobility, like turning and moving in the bed. I have helped get R72 out of bed into the dining room about 10 times since May of this year. I do the restorative programs in his bedroom the majority of the time. Facility document titled, Restorative dated 9/9/24 through 9/21/24, documents R72 having active range of motion and dressing therapy by restorative aides but there is no documentation of transferring and walking therapy being done with R72. On 9/24/22 at 2:12pm, V2 (Director of Nursing) said, There's no documentation on him (R72) getting out of bed and out of his room. I cannot find anything. Staff usually don't chart when they get the residents out bed. The staff get the majority of the residents on the floor up so that's a lot to chart. This surveyor told V2 that on 9/22/24 at 12:10pm, this surveyor notified V7 (Registered Nurse) that R72 alleged to this surveyor that he never leaves his room because staff won't assist him out of bed. After V7 was notified, there were 2 progress notes in R72's EMR (electronic medical record) documenting that R72 was up sitting up in the chair. V2 replied, Really? Of course, they're documenting it now. I guess they're starting to do that today. I've been here since May. Honestly, I don't know if I ever seen R72 out of bed and out of his room. The abuse coordinator is the Administrator. If they (residents) don't get up they can become lonely, depressed, weaker, inability to do things they used to be able to do. I honestly don't know if R72 is experiencing these issues. R72's progress notes by V7 (Registered Nurse), dated 9/22/24 at 1:17pm, documents, in part, up in chair . (charted after this surveyor notified the facility that R72 alleged to this surveyor that he never leaves his room because staff won't assist him out of bed.) R72's progress note by V56 (Licensed Practical Nurse), dated 9/22/24 at 5:02pm, documents, in part, . Resident sitting up in chair in day room comfortably. Will continue to monitor. (Charted after this surveyor notified the facility that R72 alleged to this surveyor that he never leaves his room because staff won't assist him out of bed.) (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/24/24 at 2:26pm, V1 (Administrator) said, Me. I'm the Abuse Coordinator. Approximately in July was the most recent in-service on Abuse. I, myself, conducted it with all staff. I came in at the end of June of this year. I wouldn't even be honest that I know all the resident's names. I don't know if I have ever seen R72 out of his room. Facility policy titled, Abuse Policy and Prevention Program, date 10/2022, documents, in part, This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents . establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment . identifying occurrences and patterns of potential mistreatment . Unreasonable confinement or Involuntary seclusion means the separation of a resident from other residents or . confinement to her/his room (with or without roommates) against the resident's will . Facility policy titled, Activities of Daily Living, reviewed date 5/2024, documents, in part, A program of activities of daily living is provided to prevent disability and return or maintain residents at their maximal level of functioning based on their diagnosis. Facility presented document titled, RESIDENTS' RIGHTS for People in Long-Term Care Facilities, revision date 11/2018, documents, in part, Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. You must not be abused, neglected, or exploited by anyone - financially, physically, verbally, mentally or sexually. Your facility must provide services to keep your physical and mental health, at their highest practical levels.

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	09/25/2024

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Ryze on the Avenue	3400 South Indiana Chicago, IL 60616

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50728 49572 Based on interview and record review, the facility failed to ensure Pre-Admission Screening and Resident Reviews (PASRRs) were completed prior to resident admission. The facility also failed to ensure properly qualified staff completed Level I Pre-Admission Screening and Resident Reviews (PASARR)This failure affects 4 (R38, R75, R110, R124) residents in a sample of 65. Findings include: 1.) Record review of R75's admission record documents in part that R75 was admitted on [DATE]. Record review of R75's PASRR Level I Screen indicates that V31 (Admissions Director) completed the level I PASSR screening for R75 on 9/23/24. 2.) Record review of R110's admission record documents in part that R110 was admitted on [DATE]. Record review of R110's PASRR Level I Screen indicates that V31 (Admissions Director) completed the level I PASSR screening for R110 on 9/23/24. 3.) Record review of R38's admission record documents in part that R38 was admitted on [DATE]. Record review of R38's PASRR Level I Screen indicates that V31 (Admissions Director) completed the level I PASSR screening for R38 on 9/23/24. 4.) R124's Admission Record documents that R124 was admitted to the facility on [DATE] and that R124's diagnoses include Schizophrenia (date 11/27/2020) and Major Depressive Disorder (date 11/27/2020). R124's Brief Interview of Mental Status (BIMS) score, dated, 7/02/24, documents, in part, a BIMs score of 13 which indicates R124 is cognitively intact. R124's (active order as of 7/23/24), Order Summary Report documents, in part, Seroquel Oral Tablet 25 MG (Quetiapine Fumarate) Give 1 tablet by mouth in the morning for SCHIZOPHRENIA and Fluoxetine HCl Capsule 20 MG Give 1 capsule by mouth in the morning for antidepressant. R124's Care Plan, created date 2/15/24, documents, in part, (R124) displays behavioral symptoms . manifested by schizophrenia. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Level I PASRR Attestation and Signature documents in part By checking this box, I attest that I have reviewed all information herein and that I take responsibility for the completeness and accuracy of information reported throughout this submission. I attest that I am a healthcare professional working in a clinical capacity for this provider. I understand that approved submitters include clinical professionals such as nurses, LPNs (Licensed Practical Nurses), social workers (with a BS (Bachelor of Science) degree or higher, physicians or home health agency staff clinical staff. Social Services staff are not required to be licensed to submit information. I understand that administrative staff are not permitted to submit clinical information to Ascend. I understand that Illinois PASRR considers knowingly submitting inaccurate, incomplete or misleading Level I information to be Medicaid fraud, and I have completed this form to the best of my knowledge. V31's name is noted under this box, attesting to this information. On 9/23/24 at 2:37 pm, V31 (Admissions Director) presented document titled, PASRR (Pre-Admission Screening and Resident Review) Pro-1 PASRR Level I Screen, dated 9/23/24 at 1:19 pm, showing that V31 requested a Level I PASRR to be done on R124 on 9/23/24. This surveyor inquired about the date R124's PASRR Level I was submitted and V31 replied, There was not one (PASRR) done on R124 for some reason. I submitted it today. There should have been one done. On 9/24/24 at 10:17 AM, V22 (Human Resources Director) confirmed that V31 does not have a nursing license, physician license, and is not a social worker with a BS degree or higher. V22 stated that V31 does not have any records on file of a collegiate education. On 9/24/24 at 2:38 PM, V46 (Social Services Director) stated that V46 completes that PASSR assessments with the social services consultant, as well as V31. V46 affirmed that V46 has a bachelor's degree but was unaware if V31 had any formalized collegiate education. V46 reviewed the Level I PASSR attestation and signature and affirmed that clinical staff members are approved to complete level I PASRR assessments. V46 affirmed that having formalized clinical knowledge is important to completing the PASSR because the PASSR asks a lot of clinical questions, like about psychiatric diagnosis and psychiatric medication use. V46 affirmed that the PASSRs were completed on 9/23/24 for R38, R110, and R75 by V31. V46 stated that PASSR assessments are important because they identify potential mental health needs of a resident and are typically completed by the hospital prior to admission. V46 opened R75's medical record and confirmed that there were no prior PASSR or OBRA-1 (PASSR screening method prior to 3/14/22) completed for R75. On 9/24/24 at 3:23 PM, V46 affirmed that V46 reviewed R75, R110 and R38's medical record and the Maximus system and no PASSR assessments were completed prior to 9/23/24. Facility policy titled, PAS (Pre-Admission Screening) SCREENING (reviewed 1/2024) documents in part, . It is the policy of this facility to: 1. Comply with Illinois standards addressing the PAS assessment/screening process. 2. Request full and complete PAS materials (Level I and 2) from each referral source prior to admission .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50728 Based on interview and record review, the facility failed to conduct care plan conferences to include the resident/responsible party in development of their plan of care. This failure affects 4 (R61, R75, R76, and R110) residents in a sample of 65. Findings include: 1.)R75's admission record documents in part that R75 was admitted on [DATE] and that R75 has been diagnosed with the following diagnoses including but not limited to, hemiplegia, heart failure, Alzheimer's disease, and osteoarthritis. R75's Minimum Data Set (MDS) dated [DATE], documents in part a brief interview of mental status summary score of 9, indicating resident is cognitively impaired. On 9/22/24 at 11:32 AM, R75 stated that R75 has never been invited to participate in a care conference or in the development of R75's plan of care. R75 stated that R75 has been here a long time and would have wanted to be invited to participate in the development of R75's plan of care. 2.)R110's admission record documents in part that R110 was admitted on [DATE] and that R110 has been diagnosed with the following diagnoses including but not limited to, chronic hepatitis c, epilepsy, cachexia, unspecified dementia, and adult failure to thrive. R110's Minimum Data Set, dated dated dated [DATE], documents in part a brief interview of mental status (BIMS) summary score of 3, indicating R110 is cognitively impaired. However, resident was able to be interviewed, answer questions, and respond appropriately. On 9/22/24 at 11:49 AM, R110 stated that R110 has not been invited to any care conferences and was unaware if R110's family had been invited to any. R110 affirmed that R110 would want to be involved in the development of R110's plan of care. 3.)R76's admission record documents in part that R76 was admitted on [DATE] and has been diagnosed with the following diagnoses including but not limited to, hemiplegia, type two diabetes mellitus, anemia, depression, anxiety disorder, altered mental status, epileptic seizures, and epilepsy. R76's Minimum Data Set, dated dated dated [DATE], documents in part a brief interview of mental status (BIMS) summary score of 13, indicating R76 is cognitively intact. On 9/22/24 at 11:39 AM, R76 stated that R76 has been last admitted to the facility about a year ago and has never had a care plan meeting or care conference to involve R76 in developing R76's plan of care. R76 stated that if there was ever a care plan meeting, R76 would want to be involved in developing R76's plan of care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4.)R61's admission record documents in part that R61 was admitted to the facility on [DATE] and has been diagnosed with the following diagnoses including but not limited to, hemiplegia, unspecified psychosis, dysphagia following cerebrovascular accident, dementia, unspecified severe protein calorie malnutrition. R61's Minimum Data Set, dated dated dated [DATE] documents in part brief interview of mental status (BIMS) summary score of 10, indicating resident is cognitively impaired. On 9/22/24 at 11:21 AM, R61 stated that R61 has been a resident for about a year. R61 stated that R61 has never been asked to participate in the development of R61's plan of care or invited to any care plan conference. R61 stated that if there were any meetings related to developing R61's plan of care, R61 would like to be invited, attend, and provide R61's input. On 9/22/24 at 1:32 PM, records for R75, R110, R76 and R61 care plan meetings/conference documentation and participation records were requested. On 9/24/24 at 1:35 PM, V54 (Registered Nurse Consultant) stated that the facility does not have records of invitation or conducting care plan conferences for R75, R110, R76 and R61. V54 stated that care plan meetings are supposed to be set up by the social services staff and conducted quarterly. On 9/24/24 at 2:00 PM, V2 (Director of Nursing) affirmed that the facility had not completed or invited R75, R110, R76 and R61 to care conferences to participate in the development in their plan of care. V2 affirmed that residents have a right to attend care plan meetings and participate in the development in their plan of care. Facility policy titled Care Conferences (dated 1/2024) documents in part, An interdisciplinary care conference, which includes the resident and their significant other, is necessary to coordinate resident needs and establish obtainable goals. By inviting the resident and/or significant other to the care plan conference, it ensures their right to participate in planning care and treatment .Policy: 1. The care plan coordinator or designee will notify the resident and resident representative of the initial and quarterly care plan conferences. 2. The resident representative will be notified in writing of the conference and the letter maintained in the resident record. 3. The initial care plan meeting is held within approximately 14 days after admission and approximately 90 days there after .5. Everyone attending the care plan conference documents their attendance. 6. The Care Plan Coordinator or designee is responsible for running the Care Plan Conference . If the resident/family attend the care conference their input will be recorded in the medical record. 9. If the resident and/or significant other cannot attend the care conference, they may request that the facility contact them after the conference to share any information from the conference. The Care Plan Coordinator or other designated team member may make this contact. 10. The Care Plan Coordinator/designee will make every effort to accommodate the resident representative's schedule; including holding the conference by phone.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50728 Based on interview and record review, the facility failed to follow a physician's order for infectious disease consult to treat a resident's diagnosis of hepatitis C. This failure affects 1 resident (R110) in the sample of 65. Findings include: R110's Admission Record documents in part a diagnosis of hepatitis C (3/23/2020). R110's Minimum Data Set, dated dated dated [DATE], documents in part a brief interview of mental status (BIMS) summary score of 3, indicating R110 is cognitively impaired. R110's physician orders document in part an active order for Infectious disease consult for Hep (hepatitis) C at (location), dated 6/15/2020. R110's care plan dated 3/24/2020 identifies that R110 has been diagnosed with hepatitis C. R110's care plan does not indicate if R110 has received treatment or follow up by an infectious disease provider. On 9/22/24 at 11:49 AM, R110 stated that R110 didn't know that R110 was diagnosed with hepatitis. R110 could not remember if R110 ever received treatment for hepatitis C. On 9/22/24 at 1:32 PM, surveyor requested documentation of the infectious disease consult and any treatment provided to R110 regarding hepatitis C. On 9/24/24 at 1:24 PM, V48 (Nurse Practitioner) affirmed that R110 is under V48's care. V48 stated that V48 is aware that R110 has an active diagnosis of hepatitis C but that hepatitis C is treated by infectious disease. V48 was not aware if R110 ever received consultation by an infectious disease specialist or treatment. V48 affirmed that hepatitis C is a treatable disease and that if left untreated in can cause harm and complications, including liver cirrhosis. On 9/24/24 at 2:00 PM, V2 (Director of Nursing) affirmed that the facility had no documentation of R110 having an appointment made for an infectious disease provider, being seen/assessed by an infectious disease provider, or receiving treatment for hepatitis C. V2 affirmed that R110 should have been seen by infectious disease and received treatment. V2 stated that V2's expectation for the facility is that orders for consultation are followed up on and appointments made. V2 stated that if hepatitis C is left untreated it could lead to liver failure, need for liver transplant or death. On 9/24/24 at 2:33 PM, V24 (Assistant Administrator/Social Worker) stated that V24 was unaware if an appointment was made for R110 to see the infectious disease provider. V24 stated that appointments were usually made by the nursing staff. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy titled, Appointments and Transportation (reviewed 2/9/2024) documents in part, . When a resident has an appointment outside of the facility, the staff will make transportation arrangements, unless the responsible party chooses to make arrangements themselves. Level of Responsibility: Nursing Staff . Procedure: 1. Unit Clerk, HIM Director or designee will call the place of the appointment to verify the date, time and location .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 45196 Based on observation, interview, and record reviewed the facility failed to assure that a resident (R29) with a pressure ulcer received necessary treatment and services to promote healing. This failure affected 1 resident (R29) out of 65 residents reviewed for wound care. Findings include: On 09/22/24 R29 was observed alert and oriented in R29's room sitting in R29's motorized chair. R29 stated that R29 has a wound on R29's buttocks area that developed a few weeks ago. R29 stated that when R29 reported pain to R29's buttocks wound to R29's nurse a few weeks ago R29's nurse placed a bandage to R29's buttocks area. When R29 asked regarding the last time R29's buttocks wound dressing was changed, R29 stated that R29 did not know. On 09/24/24 at 9:09 am, Surveyor requested V5 (Licensed Practical Nurse/Wound Care Nurse) and V32 (LPN/Wound Care Nurse) to perform a skin check and dressing change to R29's buttocks wound. V5 stated, She (R29) does not have a wound on her (R29) buttocks. Upon V5's skin assessment of R29, the surveyor, V5 and V32 observed a piece of undated tape to R29's left buttocks area. Surveyor then observed V5 remove the tape from R29's left buttocks area and observed an open wound to R29's buttocks area that was 100% granular in color with scant serous drainage. V5 stated, I (V5) did not know that she (R29) had that. No one reported to me (V5) that she had an open wound on her buttocks. I (V5) change her (R29's) left heel wound every day and I did not see that (referring to the open area to R29's left buttocks. V32 then stated, I (V32) did not know she (R29) had it (referring to the open area to R29's left buttocks) either. When surveyor questioned V5 regarding the type and staging of the area observed to R29's left buttocks, V5 then stated that the open area to R29's left buttocks was a stage 2 pressure ulcer and that V5 would apply a hydrocolloid dressing to R29's left buttocks. Surveyor requested V5 to measure the open area to R29's buttocks and V5 measured the open area to R29's left buttocks as 1.0 x 1.0 x 0 cm (centimeters). When V5 and V32 was asked regarding the importance of a resident to received wound care to an open pressure ulcer and V5 stated, So that the wound does not decline. On 09/24/24 at 12:45 pm, Surveyor questioned V5 regarding R29's wound care orders and V5 stated that R29 did not have treatment orders to R29's left buttocks wound. V5 then explained that R29's Treatment Administration Record (TAR) had a treatment in place that did not specify a site to be treated that V5 believes was for R29's buttocks wound. V5 then explained that V5 overlooked the treatment order without an indication of a site to be treated due to the treatment order not having a specific site causing V5 to oversight treating R29's left buttocks wound. V5 was asked regarding how often R29's skin was assessed and V5 stated, I (V5) was only looking at R29's heel wound. Her (R29) skin should have been assessed every day. When V5 was asked regarding the importance of following physicians order for skin checks and V5 stated so that you are aware of any new areas in need of wound care and treatment on a resident. On 09/24/24 at 2:40 pm, V2 (Director of Nursing) was questioned regarding what could happen if a treatment order does not indicate a site to be treated and V2 stated, Staff won't know where to apply the treatment and the wound can get worse. Surveyor and V2 reviewed R29's TAR and Physicians Order Sheet (POS) which did not indicate a treatment order for R29's left buttocks wound. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R29's TAR dated Sep (September) 2024 shows R29 has treatment orders for Cleans (Cleanse) area with normal saline, apply dry dressing every 24 hours as needed for prophylactic to begin 09/03/24. R29's POS dated 09/03/24 documents, in part: Cleans (Cleanse) area with normal saline, apply dry dressing every 24 hours as needed for prophylactic. R29's POS dated 04/22/24 documents, in part: Complete Weekly Skin Check to ensure no new skin alterations are present. (If new alterations are present complete new Skin Condition assessment) every day shift every Fri (Friday). R29's progress note dated 09/03/24 at 10:12 pm, authored by V35 (LPN) documents, in part: Skin alteration to left buttocks noted during care, area cleansed order for dry dressing received. The facility's policy dated 01/2024 and titled Skin Care Prevention documents, in part: All residents will receive appropriate care to decrease the risk of skin breakdown . Guideline: dependent residents will be assessed during care for any changes in skin condition including redness (non-blanching erythema), 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.

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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. 50662 Based on observation, interview and record review, the facility failed to provide a safe environment with laundry chute left unlocked and accessible to residents on the 3rd floor dementia unit. The facility also failed to ensure one resident (R48) has no access to an item that could potentially be used as a weapon against staff or other residents. These failures affected one resident (R48) and have the potential to affect 67 residents on the 3rd floor and 66 residents on the 4th floor. Findings include: 1.) On 09/23/24 at 09:55am observed soiled utility room with no lock and linen chute in soiled utility with no lock. Multiple residents ambulating freely throughout halls. On 09/23/24 at 10:23am V30 (Licensed Practical Nurse) stated, I'm not sure why the doors to the dirty linen room doesn't have a lock on it. Working on the dementia floor there are a lot of things that create a risk. The laundry chute could pose a risk for the residents. On 09/24/24 at 2:27pm V2 (Director of Nursing) stated, 3rd floor is the dementia floor. The dementia residents are confused. They wander throughout the unit. Extra safety measures should be in place for this population. The laundry chutes go down to the basement. An unlocked room with an unlocked laundry chute is considered a safety risk. The residents could injure themselves on the chute. The residents could fall down the chute and die. The laundry chute room should be locked at all times. We (facility) do not have a policy on safety and hazards. On 09/24/24 at 3:12pm V1 (Administrator) email states, The facility does not have a hazard policy. The Illinois Long-Term Care Ombudsman Program titled Residents' Rights for People in Long-Term Care Facilities dated 11/18 documents in part, Your facility must be safe, clean, comfortable and homelike. 43351 2.) On 09/22/2024 at 10:53am, there was a steak knife on top of R48's beside table. R48 stated I don't like people coming into my room. I have a steak knife for my protection. On 09/22/2024 at 11:11am, this surveyor requested V11 (Licensed Practical Nurse/LPN) to check R48's bedside table. V11 stated he (R48) has a steak knife. This surveyor, with V11 present, inquired R48 why R48 has a steak knife in his room. R48 stated because I don't trust people. I need to protect myself. V11 took the knife outside of R48's room. On 09/22/24 11:16 AM outside of R48's room, V11 stated I did not know he had a knife. R48 should not have a knife at all because it may cause harm to himself or other residents. And that is what he basically said to us, to protect himself. His intention is to use the steak knife on whoever comes in his room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/23/2024 at 12:34pm, V2 (Director of Nursing) stated there should be no weapon inside the resident's room at no time that could potentially harm other residents or the resident himself. A steak knife can be used as weapon or to cut food. V2 was informed that R48 made a statement I don't like people coming into my room. I have a steak knife for my protection. and I don't trust people. I need to protect myself. V2 stated with these statements, R48's intent is to use to the steak knife as a weapon. R48's (09/22/2024) Order Summary Report documented, in part Diagnoses: (include but not limited to) cerebrovascular disease, hypertension, and personal history of traumatic fracture. R48's (07/26/2024) Minimum Data Set documented, in part Section C0500. BIMS (Brief Interview for mental status) Summary Score: 15. Indicating R48's mental status as cognitively intact. The (09/24/2024) email correspondence with V1 (Administrator) documented, in part The facility does not have a hazard policy. The facility expects all residents to conduct themselves in a safe manner and to refrain from engaging in any actions that can cause the resident, resident's peers, employees of the facility and visitors of the facility any harm. In regards to any resident having possession of a steak knife; the facility has the reasonable expectation that a resident being in possession of a steak knife will, immediately, turn the steak knife over to staff and make use of the facility's provided eating utensils.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 45196 Based on observation, interview, and record review the facility failed to ensure a resident (R129) indwelling catheter bag was changed. This failure affected one resident (R129) in the sample of 65 residents. Findings include: R129's face sheet shows that R129's has diagnosis which include but not limited to neuromuscular dysfunction of bladder and paraplegic. R129's Brief Interview for Mental Status (BIMS) dated 06/28/24 shows that R129 has a BIMS of 15 which indicates that R129 is cognitively intact. On 09/22/24 at 10:58 am, R129 was observed sitting in R129's wheelchair in R129's room with R129's indwelling catheter attached to the side of R129's wheelchair. R129 stated that R129's indwelling catheter bag has not been changed in 2 months and that R129 informed staff that R129's indwelling catheter bag was soiled and has been asking for staff for over a month for R129's indwelling catheter bag to be changed. Surveyor observed R129's indwelling catheter bag without a date, cloudy urine and with a brownish discoloration to R129's indwelling catheter bag. R129 stated, They (referring to staff) don't change it (referring to R129's indwelling catheter bag). It (referring to R129's indwelling catheter bag) has not been changed for long time. I (R129) don't want to get another UTI (urinary tract infection). On 09/24/24 at 1:02 pm, V2 (Director of Nursing) stated that indwelling catheters are changed according to the resident's physician's orders and if the indwelling catheter bag is dirty or discolored. When V2 was asked regarding the importance of changing the residents indwelling catheter bag if the indwelling catheter bag becomes soiled or discolored and V2 explained if a residents indwelling catheter bag is discolored with visible dirt the indwelling catheter bag should be changed to decrease the risk of the resident acquiring an infection and for the overall health of the resident. The facility's policy dated 01/2024 and titled Equipment Change Schedule Nursing documents, in part: Policy: Equipment will be changed following established scheduled to prevent cross contamination . 3. Foley (Indwelling Catheter) a) Foley (Indwelling Catheter) bags are changed only if they become cloudy, leak, or have an odor. The facility's policy dated 01/2024 and titled Indwelling Catheter Care documents, in part: Policy: Daily and prn (as needed) catheter care will be done to promote comfort and cleanliness. R129's Physician's Order Sheet (POS) dated 08/08/24 documents, in part: Change urinary bag as needed when clinically appropriate as needed . Provide Catheter care Q (every) shift and prn every shift.

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	09/25/2024

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 41611 Based on observation, interview, and record review the facility failed to ensure an enteral feeding formula was changed in a timely for one resident (R209). This failure affected 1 of 8 residents who receive gastrostomy tube feedings. Findings include: R209 has a diagnosis of Acute Respiratory Failure, Unspecified Whether with Hypoxia Or Hypercapnia, Dysphagia, Pharyngoesophageal Phase, Pneumonitis Due To Inhalation Of Food And Vomit, Dyskinesia Of Esophagus, Dysphagia, Esophageal Obstruction. R209 has a Brief Interview of Mental Status score of 14. R209's Order Summary Report documents, in part, Enteral Feed Order every shift Enteral Feeding Formula: (Brand name of enteral feeding) 1.5 cal Rate 80 ml/hr (hour) total volume 1280 on at 4:00pm. R209's Dietary Evaluation with a date of 7/30/2024 documents, in part, (Brand name of enteral feeding) 1.5 to infuse 1280 mL/d @ 80 mL/hr; Flush @ 300mL q shift (TID). R209's Admission Evaluation dated 7/24/2024 documents, in part, Enteral Feeding. R209's care plan focus tube feedings, document, in part, resident will receive tube feeding and water flushes per physician orders. On 9/22/2024 at 11:36am surveyor observed R203's almost full G-tube (gastrostomy tube) feeding bottle opened with a date of 9/19/2024. On 9/22/2024 at 11:40am V7 (Registered Nurse/RN) said, I see 9/19 and today is the 22nd of September on the R209's Gastrointestinal feeding and feeding should be changed daily. On 9/22/2024 at 11:45am V57 (RN) came in and removed R209's G-tube feeding bottle dated 9/19. On 9/24/2024 at 2:17pm V2 (Director of Nursing/DON) stated a resident's G-tube feeding is good for 24 hours and should be discarded after 24 hours of being opened. V2 also stated If it (g-tube feeding) is not discarded it could make the resident sick. On 9/25/2024 via email V2 (DON) stated if a resident ingests g-tube feeding that is 2 days old, several issues could arise, primarily related to food safety and nutritional quality. Tube feeding formulas are typically designed to be used within a specific time frame, often 24 hours after opening. If it's been sitting for 2 days, harmful bacteria (such as E. coli, Salmonella, or Listeria) could grow in the formula, potentially leading to foodborne illness. Over time, the nutritional content of the feeding can degrade, meaning the resident may not get the intended number of calories, proteins, vitamins, or minerals. This could be problematic for individuals relying on g-tube feedings as their primary source of nutrition. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy titled Tube Feeding with a revised date of 1/2024 documents, in part, 1. Continuous tube feedings are based upon a 22-hour consumption period or other time frame based on individual resident need per Registered Dietician assessment and delivered over a 24-hour period, and tube feedings and tubing via closed system will be changed per manufacturer's instructions. Policy titled Equipment Change Schedule with a revision date of 1/2024 documents, in part, change enteral feeding solution and bag/bottle Q (every) 48 hours and PRN (as needed).

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 41611 Based on observation, interview, and record review the facility failed to label and date respiratory equipment (nasal cannulas and humidifier bottles). The facility also failed to ensure there was a physician's order for oxygen therapy. This failure affected 4 residents (R72, R100, R209, R276) who receive oxygen therapy. Findings include: 1.) R100 has a diagnosis of but not limited to Chronic Obstructive Pulmonary Disease, Shortness of Breath, and Dependence on Supplemental Oxygen. R100 has a Brief Interview of Mental Status score of 09. Surveyor reviewed R100's Order Summary Report with active orders as of 9/24/2024 that does not document an order for oxygen. R100's care plan focus respiratory dated 9/24/2024 documents, in part, administer medications/treatments as ordered, administer oxygen as ordered and monitor oxygen saturation. On 9/22/2024 at 12:03pm surveyor observed R100's oxygen tubing and humidifier bottle that was not dated. 2.) R209 has a diagnosis of but not limited to Acute Respiratory Failure, Unspecified Whether with Hypoxia Or Hypercapnia, Dysphagia, Pharyngoesophageal Phase, Pneumonitis Due To Inhalation Of Food And Vomit, Dyskinesia Of Esophagus, Dysphagia, Esophageal Obstruction. R209 has a Brief Interview of Mental Status score of 14. R209's care plan for respiratory dated 9/24/2024 documents, in part, administer medication/treatments as ordered and administer oxygen as ordered. Surveyor reviewed R209's Order Summary Report with active orders as of 9/24/2024 documents, in part, oxygen at 3 liters/minute per nasal cannula. 3.) R276 has a diagnosis of but not limited to Chronic Respiratory Failure, Dyspnea, and Dependence on Supplemental Oxygen. R276 has a Brief Interview of Mental Status score of 15. Surveyor reviewed R276's Order Summary Report with active orders as of 9/24/2024 that does not document an order for oxygen. R276's care plan focus: Respiratory dated 9/05/2024 documents, in part, administer medications/treatments as ordered and monitor oxygen saturation. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/22/2024 at 11:35AM surveyor observed oxygen tubing and humidifier bottle with no date. On 9/22/2024 at 11:40am V9 (Registered Nurse/RN) stated that there is no label on the oxygen tubing or humidifier bottle, and it should be labeled. On 9/22/2024 at 12:10pm surveyor observed R276 oxygen tubing and humidifier bottle with no date. On 9/24/2024 at 10:27am V34 (RN) stated oxygen tubing and humidifier bottles should be labeled with the date and changed once a week. On 9/24/2024 at 2:17pm V2 (Director of Nursing/DON) stated a resident's oxygen tubing and humidifier bottle should be changed weekly and/or as needed and should be dated when it is changed. On 9/25/2024 at 1:55pm via email V2 (DON) said, Yes, a physician's order is required for residents who require oxygen therapy. This is important for several reasons, Oxygen is considered a medication, and like any medication, it needs to be prescribed based on a resident's specific medical condition. The physician's order ensures the proper flow rate and delivery method (e.g., nasal cannula, mask) are tailored to the resident's needs. Too much or too little oxygen can be harmful. 49572 4.) On 9/22/24 at 11:04am, R72 was observed in R72's room, lying on R72's back in bed, with a nasal cannula in R72's nose at 2 liters of oxygen. The nasal cannula and humidifier bottle were not labeled with a date. This surveyor asked R72 when the nasal cannula oxygen tubing and humidifier bottle were last changed and R72 replied, I (R72) am not sure. R72's Face sheet, documents, in part, medical diagnosis including but not limited to chronic obstructive pulmonary disease, unspecified, chronic embolism and thrombosis of deep veins of lower extremity, seizures, and morbid (severe) obesity due to excess calories. R72's Brief Interview of Mental Status (BIMS) score, dated, 6/18/24, documents, in part, a BIMs score of 13 which indicates R72 is cognitively intact. R72's Order Summary Report, dated 9/23/24, documents, in part, Change Oxygen Tubing every night shift every Wed (Wednesday) . Oxygen (02) @ (at) 2-3Liters/Minute per nasal cannula, Maintain 02 Saturation @ 92% or greater every shift for SOB (shortness of breath) R72's Care Plan, revision date 8/14/24, document in part, (R72) has Oxygen Therapy r/t (related to) dx of COPD (chronic obstructive pulmonary disease) . Administer oxygen per physician's orders: 2-3 L/Min. per N/C nasal cannula), maintain 02 Sats at 92% or greater. On 9/22/24 at 11:17 am, while in R72's room, when asked when R72's nasal cannula tubing and humidifier bottle were last changed. V7 (Registered Nurse/RN) grabbed R72's oxygen tubing and looked from the top of the oxygen tubing to the bottom of the oxygen tubing and replied, I (V7) don't know when it was changed. There's no date on it. I'll have to change it now cause there's no way to tell. It should be changed every 3 days cause of germs. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility policy titled, Equipment Changing Schedule, revision date 1/2024, documents, in part, 1. Oxygen: a) Oxygen tubing, nasal cannula and masks are changed weekly and PRN. b) Check water levels in humidifier jar every shift and change humidifier jar weekly and pm. Change pre-filled humidifier when water level becomes low or weekly and pm. c)Aerosol set up: device, tubing, drain bag and humidifier jar changed weekly and pm.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 50728 Based on observation, interview and record review, the facility failed to ensure controlled substances were stored appropriately. This failure affects 1 resident (R7) in a sample of 65. Findings include: On 9/23/24 at 09:37 AM, V21 (Licensed Practical Nurse) observed the refrigerator in the 3rd floor medication room. V21 stated that the refrigerator should be locked. An open padlock was noted on the counter above the refrigerator. V21 withdrew R7's vial of Lorazepam (controlled substance) from the refrigerator. V21 affirmed that R7's Lorazepam is a controlled substance and must be kept locked. Additionally, within the refrigerator was unopened insulin pens, bisacodyl suppositories, acetaminophen suppositories, and a vial of haloperidol lactate. No additional lock box or device was observed in the refrigerator that would prevent the lorazepam from being stored with non-controlled medications. On 9/24/24 at 2:00 PM, V2 (Director of Nursing) affirmed that all controlled substances should be kept locked behind a system of 2 locks. V2 stated the two-lock system for refrigerated medications is the lock on the door of the medication room and a lock on the fridge. V2 stated that it is important for controlled substances to be behind two locks because it helps to prevent residents from accidentally consuming the medication and to prevent diversion of controlled substances. Review of facility policy titled, Medication Storage In The Facility, (Reviewed 1/2024) documents in part, .3. Medication rooms, carts, and medication supplies are locked or attended by person with authorized access . 9.All drugs classified as Schedule II-V medications must be maintained in a separately locked, permanently affixed compartments and cannot be stored with other non-scheduled medications .

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43351 Based on observation, interview, record review, the facility failed to ensure the personal refrigerator temperature log had no missing temperatures, failed to ensure a thermometer is available inside a personal refrigerator and failed to ensure the personal refrigerator has no expired food items. These failures affected 6 (R1, R11, R48, R92, R120, and R202) residents reviewed for personal food in the total sample of 65 residents. Findings include: 1.) On [DATE] at 10:53 am, there was a small refrigerator inside R48's room. There were missing temperatures on the Temperature log. On [DATE] at 11:06 am, this surveyor requested V11 (Licensed Practice Nurse/LPN) to check the food items inside R48's refrigerator. V11 opened the refrigerator, there were milk cartons inside the refrigerator. V11 checked the expiration dates of the 2 cartons of 2% milk, V11 stated the expiration date in on [DATE]. V11 checked the expiration date of 1 carton of whole milk, V11 stated [DATE]. V11 checked R48's [DATE] personal refrigerator temperature log. V11 stated there are no temps from [DATE] through [DATE]. On [DATE] at 11:15 am, outside of R48's room, V11 stated R48's temperature log is not completed for 7 days total. The refrigerator should be checked daily to make sure nothing is going bad and to check the temperature is in the normal temp. The expired food items should not be in the refrigerator because it can cause harm to the resident and the resident may get sick from ingesting the milk. R48's (,d+[DATE]) Temperature Log had missing temperature from [DATE] through [DATE]. R48's ([DATE]) Order Summary Report documented, in part Diagnoses: (include but not limited to) cerebrovascular disease, hypertension, and personal history of traumatic fracture. R48's ([DATE]) Minimum Data Set documented, in part Section C0500. BIMS (Brief Interview for mental status) Summary Score: 15. Indicating R48's mental status as cognitively intact. 2.) On [DATE] 11:53 am, there was a small refrigerator inside R92's room. R92's personal refrigerator temperature log has missing temperatures. V11 stated no temperatures were logged on [DATE], [DATE], [DATE], and [DATE]. R92's (,d+[DATE]) Temperature Log had missing temperatures on [DATE], [DATE], [DATE], and [DATE]. R92's ([DATE]) Order Summary Report documented, in part Diagnoses: (include but not limited to) hypertension, hyperlipidemia, and mild protein calorie malnutrition. R92's ([DATE]) Minimum Data Set documented, in part Section C0500. BIMS (Brief Interview for mental status) Summary Score: 14 Indicating R92's mental status as cognitively intact. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 12:36pm, V2 (Director of Nursing/DON) stated I expect the refrigerator temperature's logged daily. The importance of checking the temperature daily is to make the holding temperature within the range 36F-41F. V2 stated I expected the expired food items be discarded, because the resident could have ingested the expired food items, and this can harm the resident and make the resident sick. The ([DATE]) Storage on Outside Food documented, in part The use and storage of foods brought to residents by family and other visitors must be monitored to ensure safe and sanitary storage, handling, and consumption. Guidelines: Daily temperatures will be recorded. 45196 3.) On [DATE] at 10:51 am, Surveyor observed R11's personal room refrigerator with an incomplete refrigerator temperature log sheet (last temperature recorded for [DATE]). R11 stated, They have not checked my refrigerator in weeks. On [DATE] at 11:47 am, V2 (DON) stated that V4 (Infection Preventionist) is responsible for checking the residents' personal refrigerator temperature logs daily. When V2 was asked regarding the importance of the residents' personal refrigerators being checked daily and logging on the temperature thermometer log sheet V2 stated, So that the residents' food doesn't spoil, and staff is not aware. The facility's document dated [DATE] and titled Temperature Log shows R11's personal refrigerator last log documented on [DATE]. R11 has a diagnosis which includes but not limited to morbid (severe) obesity due to excess calories. R11 Brief Interview for Mental Status (BIMS) dated [DATE] documents that R11 has a BIMS score of 15 which indicates that R11 is cognitively intact. 45346 4.) On [DATE] at 9:45am observed a black personal refrigerator sitting on the floor, next to R202's bed. Upon opening the refrigerator door, no thermometer observed inside the refrigerator, observed a tray of food inside the refrigerator, no temperature log observed near R202's personal refrigerator. R202 stated I had my family bring the refrigerator to me from home. R202 stated the staff are not checking the temperature inside the refrigerator. R202's Brief Interview for Mental Status (BIMS) dated [DATE] Section C C0500 documents that R202 has a BIMS score of 15 which indicates that R202's cognition is intact. 5.) On [DATE] at 9:50am observed a white refrigerator sitting on the floor inside of R1's room. Upon opening the door to R1's personal refrigerator observed two half pint (236ml) cartons of whole milk, one carton had a best by date of [DATE] and the other carton had a best by date of [DATE]. R1 stated the staff come in every day to check the temperature in the refrigerator. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 9:56am V36(Certified Nursing Assistant/CNA) stated the activity staff person, or the unit manager is responsible for checking the temperatures in a resident's personal refrigerator and for removing expired food items from the refrigerator. On [DATE] at 10:01am V37(CNA) stated I see the activities staff, the unit managers, and sometimes the caseworkers checking the temperatures and checking for expired food items in resident's personal refrigerators. On [DATE] at 10:04am observed the inside of R1's refrigerator with the same two half pint (236ml) cartons of whole milk, one carton had a best by date of [DATE] and the other carton had a best by date of [DATE]. On [DATE] at 1:04pm V34 (Registered Nurse) was asked to come into R1's room and observe the contents in R1's refrigerator. V34 pulled two cartons of milk from the top shelf of R1's refrigerator. Surveyor inquired about the expiration dates listed on the two cartons of milk. V34 stated one carton of milk has a best by date of [DATE] and the other carton milk has a best by date of [DATE]. V34 stated these cartons of milk are expired. When V34 was asked what would happen if R1 consumed those expired cartons of milk, V34 stated, R1 would have gotten very sick. V34 stated I will dump these cartons of milk immediately. On [DATE] at 2:30pm V2(DON) stated the food would spoil and the resident will become sick if the temperature in a resident's personal refrigerator is not within an acceptable range. V2 stated the importance of having a thermometer inside of a resident's personal refrigerator is so that you can know the temperature in the resident's personal refrigerator and the food can stay fresh. V2 stated the staff should be checking the resident's personal refrigerators for expired foods. R1's Brief Interview for Mental Status (BIMS) dated [DATE] Section C C0500 documents that R1 has a BIMS score of 11 which indicates that R1's cognition is moderately impaired. 49572 6.) On [DATE] at 11:10am, R120's personal refrigerator was observed with missing temperature readings and signatures on R120's Temperature Log. This surveyor inquired if staff come and check R120's personal refrigerator every day to make sure it's functioning properly, there's no expired food and it's clean. R120 replied, Oh yeah, they come check it, just not every day. R120's Face sheet, documents, in part, medical diagnosis including but not limited to cerebral infarction, unspecified muscle weakness (generalized), unsteadiness on feet and other abnormalities of gait and mobility. R120's Brief Interview of Mental Status (BIMS) score, dated, [DATE], documents, in part, a BIMs score of 14 which indicates R120 is cognitively intact. R120's Temperature Log [DATE], had missing temperature readings and signatures on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. R120's Temperature Log [DATE], had missing signatures for the whole month of September.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 45196 Based on observation, interview, and record review the facility failed to ensure a resident (R129) with an indwelling catheter was placed on Enhanced Barrier Precautions (EBP); failed to ensure a resident (R29) with EBP had a Personal Protective Equipment (PPE) bin in place; and failed to ensure staff don PPE while providing high contact resident care for a resident (R29) with EBP. These failures affected two residents (R29 and R129). Findings include: On 09/22/24 at 9:50 am, V1 (Administrator) presented a facility census of 29 residents on the first floor. R29's face sheet shows that R29's has diagnosis which include but not limited to pressure ulcer of left buttock, stage 3. R29's Brief Interview for Mental Status (BIMS) dated 08/29/24 shows that R29 has a BIMS score of 14 which indicates that R29 is cognitively intact. R129's face sheet shows that R129's has diagnosis which include but not limited to neuromuscular dysfunction of bladder and paraplegic. R129's Brief Interview for Mental Status (BIMS) dated 06/28/24 d shows that R129 has a BIMS of 15 which indicates that R129 is cognitively intact. On 09/22/24 at 9:45 am, Surveyor toured the first-floor unit and did not observe any resident rooms with PPE bins or PPE supplies for staff use on the first-floor unit. On 09/22/24 at 9:52 am, Surveyor observed R129 in bed resting with no EBP sign or Personal Protective Equipment (PPE) bin inside or near R129's room. On 09/22/24 at 11:19 am, Surveyor observed R29 in R29's room with a EBP sign on R29's door and no EBP bin inside or near R29's room. On 09/22/24 at 12:26 pm, Surveyor questioned V20 (Licensed Practical Nurse/LPN) regarding Enhanced Barrier Precautions (EBP) for the first-floor unit and V20 stated, I don't know what EBP is. That sign has been on that door (referring to R29's door) since the last two times I worked with R29. I don't know why that isolation sign (referring to the EBP sign on R29's door) is up there. When V20 was asked regarding where the isolation PPE bins were for R29's room and the first-floor unit, V20 stated, I (V20) don't know that either. When V20 was asked regarding PPE for residents with Enhanced Barrier Precaution V20 stated, You (referring to staff) should put on a gown, gloves, and a mask for residents on EBP because they (referring to the resident) is on isolation. When V20 was asked regarding what can happen if proper PPE is not worn in a resident's room that requires EBP and V20 stated, You (referring to staff) can carry germs in and out the room (referring to the resident's room that require EBP). (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	09/25/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/24/24 at 9:16 am, Surveyor observed R29's door with a sign that stated EBP Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following high contact resident care activities dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs for assisting with toileting, device care or use: Central line, urinary catheter, feeding tube, tracheostomy. Wound care: Any skin opening requiring a dressing. Surveyor then observed R29 in bed with a dressing to R29's left foot and V33 (Certified Nursing Assistant/CNA) performing high-contact resident care (performing ADL (Activities of Daily Living) care (bathing) and hygiene care) to R29 without wearing PPE (gown) in R29's room. Surveyor also observed V5 (LPN/Wound Care Nurse) performing high-contact resident care activities (wound care for a wound observed on R29's left buttocks area) without wearing PPE (gown) in R29's room. Surveyor questioned V33 regarding EBP and V33 stated, I (V33) was not paying attention to the EBP sign. I (V33) should have been wearing a gown (referring to not wearing a gown while providing ADL care to R29). V5 was questioned regarding EBP and V5 stated, It was surprising to me (V5) to see her (R29) with a wound on her (R29) buttocks, so I (V5) was not thinking about the EBP sign. When V5 was asked regarding the facility's policy for residents who require EBP and V5 stated that if a resident has a wound staff should be wearing gloves and a gown to protect themselves and residents from body fluids and getting and infection. On 09/24/24, at 9:29 am V4 (Infection Preventionist/LPN) was asked regarding the facility's policy for residents who require EBP and V4 stated, EBP is an extra standard precaution when you (referring to staff) come into contact with blood, and anything that may splash. V4 then explained that residents with wounds, indwelling catheters, and dialysis require staff to wear proper PPE (gown and gloves) when providing care, the residents room should have a EBP sign posted on the resident's door and a PPE bin outside the resident's room. When V4 was asked regarding the importance of EBP and V4 stated, If staff don't wear proper PPE, they (referring to staff) are putting either themselves or the resident in danger of getting an infection or giving an infection to the resident. When V4 was asked regarding how staff are made aware if a resident requires EBP precautions if the resident does not have a EBP sign or EBP orders and V4 stated, You (referring to the staff) wouldn't know. When V4 was asked regarding the first floor not having PPE bins for staff use on 09/22/24 and V4 stated, We did not have enough PPE bins in the building to supply the first floor with PPE bins. I (V4) had to go out to the local store Sunday (referring to 09/22/24) to buy more PPE bins. The facility's undated document titled Enhanced Barrier Precautions shows that R29 requires EBP for wound care and R129 requires EBP for indwelling catheter. R29's Physician Order Sheet (POS) does not document EBP orders for R29. R29's POS dated 09/23/24 documents, in part Left heel: Cleanse with NSS (normal saline solution), pat dry and apply calcium alginate cover with foam dressing every M-W-F (Monday-Wednesday-Friday) and prn (as needed) one time a day every Mon, Wed, Fri (Monday-Wednesday-Friday) for wound healing. R129's POS does not document EBP orders for R129. R129'S POS dated 08/08/24 documents, in part: Catheter: Suprapubic Catheter size 18 fr (French) with 10 cc (cubic centimeter) balloon. (continued on next page)

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	145337	A. Building B. Wing	09/25/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility undated document (sign) titled Enhanced Barrier Precautions Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following high contact resident care activities Dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs for assisting with toileting, device care or use: Central line, urinary catheter, feeding tube, tracheostomy. Wound care: Any skin opening requiring a dressing. The facility's document dated 01/2/24 and titled IC-Enhanced Barrier Precautions (EBP) documents, in part: General: EBP: expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of Drop's (Multidrug-Resistant Organism) to staff hands and clothing . Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with Drop's. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of Drop's colonization as well as for residents with Drop's infection or colonization. Policy: EBP requires the use of gown and gloves for use during high contact resident care activities that provide opportunities for transfer of Drop's to staff hands and clothing . High-contact resident care activities requiring gown and glove use among residents that trigger EBP use include: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, and wound care.

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	09/25/2024

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 43351 Based on observation, interview and record review, the facility failed to ensure the 4 dryers have no accumulation of lint to provide a safe environment to the residents. These failures have the potential to affect all residents in the facility. Findings include: On 09/22/2024 at 9:50am, V17 (Laundry Personnel) pointed to this surveyor the 4 dryers inside the laundry room and stated the dryers are labeled 1, 2, 3, and 4 from left to right. V17 stated the expectation is to clean the lint trap every 2 hours to prevent fire. We have a log when the lint trap is cleaned. V17 showed this surveyor the lint trap log and noted the last entry on the log documented 7. V17 stated the other staff (V50 Laundry Personnel) cleaned the lint trap at 7am. This surveyor requested V17 to open the lint traps of the 4 dryers. All the lint traps have accumulations of lint. V17 stated V50 did not clean the lint traps and it may cause fire. V17 said V17 know that for a fact. On 09/23/2024 at 12:39pm, V2 (Director of Nursing) stated (V2) expect the lint trap to be cleaned as scheduled and as needed to prevent fire or damage to the dryer. The (undated) Lint Screen cleaning /Drain Cleaning documented, in part All Laundry personnel should be trained to clean the lint screens in dryers. As dryers run, lint will accumulate inside the dryers. To keep the lint from travelling up to the top of the dryers, near the flame, the dryers are equipped with a screen to catch lint and hold it away from the flame. These screens will eventually be covered with lint and must be cleaned. If not cleaned, the screens will prevent air form circulating through the dryers and is a definite fire hazard.