STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001689	A. BUILDING: _____ B. WING _____	C 10/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RYZE ON THE AVENUE	3400 SOUTH INDIANA CHICAGO, IL 60616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Investigation of Facility Reported Incident of August 25, 2023/IL164895	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b)5) 300.1210d)6 Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 5) All nursing personnel shall assist and encourage residents with ambulation and safe	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to follow its policy and procedures for Fall Prevention for one (R1) of three residents reviewed for falls. This failure resulted in R1 sustaining a fall resulting in a head injury and R1 requiring stitches to the left eyebrow. Findings include: On 10/14/2023 at 9:30 am, R1 was observed lying in bed awake. R1 said he fell a while ago and hurt his left eyebrow and was taken to the hospital and he received 4 stitches. R1 said he fell trying to reach for his TV remote which was on his bedside table and the bedside table was placed far away from him, and he could not reach it. R1 said he had pressed his call light, but it was not working. R1 pointed to his left eyebrow and	S9999		

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S9999	Continued From page 2 said that is where he had four stitches and said now there is a scar. R1's bed was observed to be on high position. R1 said he does not know where his bed remote is. On 10/14/2023 at 9:35 am, surveyor and V3 (Licensed Practical Nurse/LPN) went to R1's room. Asked V3 about the position of R1's bed. V3 said R1's bed was in high position and said R1 could have manipulated the bed. R1 said he does not know where his bed remote is, and he has not touched it this morning. V3 looked for R1's bed remote and it was observed to be at the head of the bed under R1's pillow. V3 said the CNAs (Certified Nursing Assistants) could have left the bed in high position when they took care of R1 this morning. V3 said R1's bed should be on low position to prevent falls. On 10/14/2023 at 1:02 pm, V15 (LPN) said when R1 fell, he told her he was trying to get his TV remote control which was on his over bed table, but the over bed table was away from him, and he had to get up to get it, and that is then said he fell. V15 said R1's over bed table should be near him. V15 said she does not know who moved R1's over bed table away from R1, and further said that the CNA could have moved it when assisting R1 with ADL care. V15 said R1 was on the floor in his room when he fell and he had a visible injury on the left upper eye, a little cut area with blood coming out. V15 said R1 was sent to the hospital and when he returned, he has stitches on his left eyebrow. V15 said residents should be safe at the facility and fall precautions should be observed by staff to prevent resident injury. On 10/14/2023 at 1:49 pm, V17 (Director of Nursing) said when she interviewed staff, R1 was	S9999		

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S9999	Continued From page 3 in bed listening to music on his phone and staff was alerted that when R1 went to reach for his TV remote which was on his over bed table, R1 had fallen out the bed. V1 said R1 was able to ambulate at the time of his fall. V17 said R1 sustained a cut on his left eyebrow, and he received three sutures at the hospital. V1 said R1 hospitalized from 8/25/2023 to the 8/27/2023. V17 said R1's bed should be in low position to prevent injuries if R1 was to fall out of his bed. V17 said if R1's bed is in high position and R1 fell, there is a higher risk of serious injuries. R1's nursing progress notes dated 8/25/2023 document R1 had a fall and had an injury on top of his left eye and was sent to the hospital. R1's nursing progress notes dated 8/25/2023 document sutures to R1's left eyebrow intact. R1's hospital records dated 8/26/2025 document R1 had a head injury/concussion and suture were applied to his head. Policy titled Fall prevention management dated 1/23 documents: -This facility is committed to maximizing each resident's physical, mental and psychosocial well-being. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible. "B"	S9999		