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 06/30/2023

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 Complaint Investigations: 2385108/IL161151 2384106/IL159954 Investigation of Facility Reported Incident of April 28, 2023/IL159916 Investigation of Facility Reported Incident of May 9, 2023/IL160470 Investigation of Facility Reported Incident of March 28, 2023/IL161011 Investigation of Facility Reported Incident of May 26, 2023/IL161015	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b)4)5) 300.1210d)6) 300.3240a) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. 5) All nursing personnel shall assist and encourage residents with ambulation and safe 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee	S9999		

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S9999	Continued From page 2 or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) This REQUIREMENT is not met as evidenced by: A.) Based on interview and record review, the facility failed to ensure that a resident remains free from neglect for one of three residents (R6) reviewed for neglect. V8 (Former Certified Nursing Assistant) failed to utilize two staff members during a mechanical lift transfer R6. This failure resulted in R6 falling from the mechanical lift and sustaining a right intertrochanteric (right hip fracture) and a right fibular fracture. B.) Based on interview and record review, the facility failed to utilize two staff members during a mechanical lift transfer for one of five residents (R6) reviewed for falls. The failure resulted in R6 falling from the mechanical lift and sustaining a right intertrochanteric (right hip fracture) and a right fibular fracture. Findings include: R6's medical record (Face Sheet) documents R6 is a 93-year-old initially admitted to the facility on 5/22/2018 with diagnoses including but not limited to: Repeated Falls, Essential Hypertension, Anemia, and Protein-Calorie Malnutrition. MDS (Minimum Data Set) dated 5/8/2023 documents R6 is severely cognitively impaired; is totally dependent upon staff with a two or more physical assist for bed mobility, transfers, and toileting, and is incontinent of bladder and bowel.	S9999		

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S9999	Continued From page 3 Facility's incident report of 5/17/2023 documents in part: It was reported on 5/9/2023 that resident sustained a fall. (R6) was observed on the floor in a right side-lying position. Upon inquiry, staff stated that during transport, (R6) shifted her weight causing the mechanical lift to tilt to the side and a fall was sustained. Noted with c/o (complaining of pain) to right lower extremity. On 5/10/2023, x-ray results revealed right intertrochanteric and right fibular fracture(s). Resident is at high risk for falls with a score of 18. (R6) is non-ambulatory, incontinent of bowel/bladder and requires extensive assistance to complete ADL (Activities of Daily Living) care and transfers. On 6/28/2023 at 10:10 AM, V11 (Human Resource Director) said she was alerted by V12 (Facility Clinical Manager) that V8 (Certified Nurse Assistant/CNA) used a mechanical lift to transfer resident (R6) improperly, and as a result resident fell from the lift. R6 was suspended immediately pending the outcome of the investigation. V8 was terminated on 5/10/2023 for neglect of a resident. V12 said that, upon hire, V8 signed off on the facility's lift policy that states two staff members are utilized for a (mechanical lift) transfer. V11 also said V8 received and signed that she received a copy of the Employee Handbook that describes abuse and neglect. Statement written by V11 (Human Resource Director) on 5/10/2023 states in part, on 5/9/2023 (V8 CNA) while working the 3p-11p shift attempted to transfer a resident (R6) with a (mechanical lift) alone and dropped the resident causing serious injury. Per the union handbook page 39-7Physical or verbal abuse, neglect, or	S9999		

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S9999	Continued From page 4	S9999		

attempting to injure residents, or other person, including any other staff member, supervisor, or manager. The above incident is defined as neglect. (Facility) has decided to terminate employment (of V8) effective 5/10/2023.

Facility's "Event Investigation Questionnaire" dated 5/29/2023 completed by V8 (Former CNA) documents: "10:15 PM I took (R6) in the room to bed. I hooked up the (mechanical lift) with all four hooks and as I move the (mechanical lift) to lower from chair (R6) slip(ped) out the side of (mechanical lift) and I try to catch her. She still fell."

V8 was not available for interview.

On 06/27/2023 at 4:15 PM via telephone, V9 (Licensed Practical Nurse) said, what I know is that a CNA (V8) came and got me. V8 told me there was a fall. I went into the room, she (R6) was on the floor. She (V8) just told me she (R6) fell during a (mechanical lift) transfer. R6 is a mechanical lift transfer, she was a (mechanical lift) transfer at the time of the fall. I did an assessment, then after I assessed her, I got her off the floor and called her physician. V9 also said two staff members are required to perform a (mechanical lift) transfer.

On 6/28/2023 at 11:20 AM V14 (CNA) said two to three staff should be present when transferring a resident using the (mechanical lift) for safety reasons. Staff could get hurt or the resident could get hurt.

On 6/28/2023 at 11:52 AM, V20 (CNA) said two staff are required when using a mechanical lift to transfer residents, for support. You can't use the controls and try to support the resident at the

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S9999	Continued From page 5 same time. The resident could fall. Facility's policy "Safe Patient Lifting Policy" (undated) states in part: "T=Total Lift Transfer with two or more caregivers (Total Assist)" On 9/28/2021 V8 signed that she received the facility's "Safe Patient Lifting Policy". On 9/28/2021 V8 signed the facility's "Employee Receipt and Acknowledgement of Employee Handbook". Facility's Abuse Prevention Program-Policy (November 22, 2017) states in part: "Neglect is a facility's failure to provide, or willful withholding of, adequate medical care, mental health treatment, psychiatric rehabilitation, personal care, or assistance with activities of daily living that is necessary to avoid physical harm, mental anguish, or mental illness of a resident. (201 ILCS 45/1-117). Neglect is also the failure to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Union Handbook (undated) Page 39, number 7 documents: "Physical or verbal abuse, neglect, or attempting to injure residents, or other person, including any other staff member, supervisor or manager." "A"	S9999		