STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003453	A. BUILDING: _____ B. WING _____	C 04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RYZE AT THE RIDGE	6450 NORTH RIDGE BLVD CHICAGO, IL 60626

(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 Investigation 2482609/IL00171498	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 320.1210d)6) 300.3210t) 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 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	S9999		

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that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3210 General

t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.

These regualtions were not met as evidenced by:

Based on interviews and record reviews, the facility failed to keep R4 free from abuse for one out of five residents reviewed for abuse. This failure resulted in R4 sustaining abrasions to the face and right wrist. A reasonable person would feel terrified and scared to be attacked by being punched and kicked while on the floor.

Findings include:

On 04/03/2024 at 12:06 PM, R4 was alert and oriented to person, place, and date. R4 had a red mark near the right eye, abrasions underneath the left eye, and a red mark to right wrist. R4 stated getting into an altercation on Monday with another resident (R5). R4 was scared because the other resident was slamming bedroom door loudly. The resident was running and cursing in the hall. R4 went to the nurses' station to ask what was going on. R4 headed back towards the bedroom. R4 stated "[resident] was using [resident's] freedom of speech. I was scared with what was going on. So, I started using my freedom of speech." R4 stated the resident went into the bedroom and then all of a sudden came back out and started attacking R4 with punches. "[Resident] just came out and started hitting me." "I got a few scratches on my head and face." R4

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stated "It was a vicious attack."

On 04/04/2024 at 10:58 AM, R10 stated "The [resident] from across the hall was slamming the door real hard and annoying people." "That [R5] was on something. [R5] was mad at everybody." R10 stated R4 asked R5 what was wrong and R5 got mad. R10 was waiting for the elevator to go downstairs when [R10] overheard R4 and R5 arguing.

On 04/03/2024 at 12:22 PM, V8 (Activity Aide) stated the other resident involved in the altercation was R5. V8 stated "[R5] was already agitated and running around here." V8 stated "[R4] came up here near the nurses' station asking what's going on and why was [R5] agitated." "I think [R4] got involved and started saying stuff like 'I'm not scare of you.'" V8 stated R5 went back to bedroom while R4 stayed standing in the hallway. V8 stated "Then [R5] came running out [R5's] room. I saw [R5] punching and kicking [R4]." "[R5] had history of aggressive behaviors and when [R5] gets worked up [R5] gets ready to fight." "You got to put [R5] on one-to-one when [R5's] agitated."

On 04/03/2024 at 2:52 PM, V12 (Housekeeping Director) stated R4 was standing by the elevators near [R4's] room with arms crossed. R5 was standing close to R4. As V12 headed to the main entrance of the building, V12 head screaming. "I turned around and [R5] was attacking [R4]." "[R4] was lying down on the floor on [R4's] back." "[R5] was standing over [R4] and punching." "[R5] was also kicking [R4]."

On 04/04/2024 at 10:11 AM, V15 (Certified Nurse Aide) stated R4 was on the floor and R5 was hitting and punching R4. V15 stated "[R5] was

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agitated." "One thing about [R5] is if [R5] get angry, [R5] will keep going back and forth." V15 stated R5 started getting agitated around 10:00 AM. R5 went to bedroom and slammed the door. V15 stated "I think it was like 30 minutes of [R5] going back and forth." R5 came to the nurses' station and then a few minutes later, staff heard screaming. V15 stated when R5 gets agitated, they involve social service and behavioral aides. They'll try to calm R5 down. V15 stated "Monday that didn't happen."

On 04/04/2024 at around 11:15 AM, V16 (Psychiatric Rehabilitation Services Director stated) stated when residents are experiencing behaviors, staff usually call social services to talk to the residents. During the morning of the altercation, V16 stated there were no social workers in the building. V16 did not arrive until after the altercation between R4 and R5. V16 stated since there was no social worker in the building, the staff should have attempted to talk and redirect R5. The staff should have had R5 on one-to-one monitoring.

On 04/03/2024 at 12:39 PM, V10 (Restorative Aide) stated R5 has history of verbal aggression. "When [R5's] like that, we have to tell the nurse and have the male CNAs (Certified Nurse Aides) watch [R5]. Get social service to deal with it and calm [R5] down. Sometimes might need one-to-one."

On 04/03/2024 at 12:18 PM, V7 (R5's assigned Nurse time of altercation) stated was not aware of R5's behaviors until after the altercation.

On 04/04/2024 at 12:58 PM, V20 (Assistant Director of Nursing) stated if R5 is agitated, R5 needs one-to-one monitoring. V20 stated if R5

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was pacing or running down the hall, that was abnormal behavior for [R5]. V20 stated staff should have intervened and assessed the situation to see why [R5] was pacing and running down the hall.

R5's comprehensive care plan contains a focus that documents in part that R5 has the potential to be physically and verbally aggressive (initiated 02/28/2024). One intervention documents in part: "Monitor/document/report [as needed] any [sign and symptoms] of resident posing danger to self and others" (initiated 02/28/2024).

V7's progress note about R4, dated 04/01/2024 10:00 AM, documents in part: "Resident was in an alleged physical altercation by co-peer without provocation in the hallway. Noted with some abrasions to the facial area."

V7's progress note about R5, dated 04/01/2024 10:00 AM, documents in part: "Resident physically attacked co-resident without provocation in the hallway. Staff intervened immediately and separated residents. Resident shouted "that is what you get for talking."

R4's After Visit Summary papers from the hospital, dated 04/01/2024 1:23 PM, documents in part diagnosis of "Abrasion."

Facility presented a plan of correction education titled "Behavioral Health: Behavioral Assessment, Management, Documentation & Interventions" at the end of January to the nurses, CNAs, activity staff, and social service staff. Training went over early signs of agitation which included fidgeting, restlessness, and pacing. Proactive approach included immediate interventions such as removing the resident from the situation to a quiet

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location; providing one-to-one calming, reassurance, and allowance to vent frustration; and increasing monitoring such as one-to-one or 15-minute safety checks. Slide six of the presentation documents in part: "However, based on the presence of resident-to-resident altercations, if the facility did not evaluate the effectiveness of the interventions and staff did not provide immediate interventions to assure the safety of residents, then the facility did not provide sufficient protection to prevent resident-to-resident abuse. Redirection alone is not a sufficiently protective response to a resident who will not be deterred from targeting other residents for abuse once he/she has been redirected."

Facility's "Abuse Policy and Prevention Program," dated 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."

(B)