Illinois Department of Public Health

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 02/02/2024

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 for January 14, 2024/IL168914	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.2210a) 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	S9999		

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 02/02/2024

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
S9999	Continued From page 1 care needs of the resident. 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 300.2210 Maintenance a) Every facility shall have an effective written plan for maintenance, including sufficient staff, appropriate equipment, and adequate supplies. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide an environment free from accident hazards for 3 (R3, R6, R7) out of 3 residents reviewed for accident hazards. This failure resulted in R3 getting a laceration that required 14 sutures to R3's left hand. Findings include: R3 is an 86-year-old male, admitted to the facility 12/12/2023 with diagnosis not limited to Acute Diastolic (Congestive) Heart Failure, Type 2 Diabetes Mellitus With Diabetic Chronic Kidney Disease, Venous Insufficiency (Chronic) (Peripheral), Bilateral Primary Osteoarthritis Of Knee, Unspecified Fall, Intervertebral Disc	S9999		

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 02/02/2024

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
S9999	Continued From page 2	S9999		

Degeneration Lumbar Region, Adult Failure to Thrive, Unspecified Protein-Calorie Malnutrition, Chronic Kidney Disease, Lack Of Coordination, Cognitive Communication Deficit, Weakness..

R3's MDS (Minimum Data Set) dated 12/22/23 documents 1.) BIMS (Brief Interview of Mental Status) score of 15/15 indicating intact cognition, 2.) R3 uses wheelchair as mobility device, 3.) R3 is dependent on staff for chair/bed transfers.

R3's completed facility reported incident (FRI) for the event on 01/14/24 8:30 PM documents wherein R3 took a staff members unattended personal item and when the staff reached toward R3 to retrieve the item R3 retracked R3's hand and scraped R3's left hand across the exposed metal part of R3's wheelchair resulting in a laceration. R3 was sent to the local hospital. R3 returned to facility on 01/15/24 with 14 sutures on left hand.

On 01/31/24 at 9:24 AM, V21 (Certified Nursing Assistant/CNA) stated V21 was assigned to R3 on 01/14/24 during the 3-11 shift and noticed that part of the foam was missing from R3's arm cushion after R3 left for the hospital. V21 stated V21 did not notice the missing foam before this event.

On 01/31/24 at 11:57 AM, V2 (Assistant Administrator) stated V2 spoke over the phone with V17 (Agency Nurse) working 3-11 shift on 01/14/24 to determine how R3 cut R3's hand. V2 stated V17 told V2 that there was foam missing from R3's left arm cushion wheelchair and V17 could see exposed metal in that area so that is likely how R3 got cut. V2 asked V17 to take a picture of R3's wheelchair which V17 did using a cell phone and sent it to V2. V2 showed surveyor

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 02/02/2024

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
S9999	Continued From page 3	S9999		

the photo of R3's wheelchair arm cushion time stamped on 01/14/24 at 8:07 PM. Surveyor could see that there was no foam covering the front portion of R3's left arm cushion, leaving a sharp edge exposed and what appears to be a thin rounded piece of metal. V2 stated R3's wheelchair was thrown out due to the exposed metal. V2 stated V2 asked V20 (Restorative Aide) to do a sweep of all the wheelchairs being used in the facility to make sure they were functional and did not have any exposed metal which could potentially cause an accident to the resident(s). V2 stated it is the Maintenance Department's responsibility to monitor equipment. V2 stated wheelchairs are pieces of equipment.

Multiple attempts were made to contact V17 to conduct a phone interview on 01/31/24 and 02/01/24 however calls were never returned.

On 01/31/24 at 10:32 AM, V20 (Restorative Certified Nursing Assistant) stated R3 is on restorative program for active range of motion but R2 often refuses but it is still offered. V20 stated V20 did not notice R3's wheelchair was broken during the times V20 went in to R3's room to offer R3's restorative services. V20 stated no one prior to 1/14/24 notified V20 that there was anything wrong with R3's wheelchair. V20 stated V20 saw R3's wheelchair in the front office following the incident. V20 stated V20 could see metal exposed on the end of the arm rest because it was not covered in foam. V20 stated the arm rest should have been fully covered all the way with foam so that there would not be any exposed metal. V20 stated if V20 had seen that exposed metal on R3's wheelchair V20 would have removed the wheelchair from the floor immediately and alerted maintenance or housekeeping that the wheelchair needed to be

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 02/02/2024

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
S9999	Continued From page 4	S9999		

thrown out. V20 stated V20 would have removed the wheelchair because it could cause harm to the resident.

On 01/31/24 at 10:50 AM, V20 stated that on 01/15/24 or 01/16/24 V20 was asked to do a facility wide audit of all wheelchairs to make sure they were functional and did not have any issues such as dysfunctional brakes, broken arm rests, missing arm cushions or any exposed metal. V20 stated the purpose of doing this audit was to monitor all wheelchairs for safety. V20 stated V20's audit did not find any other wheelchairs with exposed metal but did find some with missing arm cushions and one wheelchair that did not lock which is a safety concern because residents can fall while trying to get in/out of the chair if their wheelchair is not able to be in a locked position. Surveyor showed V20 the floor list of the wheelchair audit and V20 confirmed this was the completed audit which was submitted to V2.

On 01/31/24 at 10:57 AM, V20 went with surveyor to the floor and using the completed wheelchair audit surveyor selected a few of the resident's names that were identified as having issues with their wheelchair.

On 01/31/24 at 11:01 AM, observed R6 sitting in wheelchair in the unit dining room. The left brake was engaged but the right brake was not activated. R6 stated the lock on her wheelchair does not work and that she's already told staff that it needs to get fixed, but nobody had fixed it yet. V20 tried to engage the right brake but could not get it to hold. V20 stated the brake did not work and needs to be replaced because it is a safety concern.

On 01/31/24 at 11:09 AM, observed R7 sitting in

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 02/02/2024

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
S9999	Continued From page 5	S9999		

wheelchair in the unit dining room. The right arm cushion was missing, and a metal bolt was observed to be protruding upward from the first nail opening. V20 observed the metal bolt and stated that is a potential safety risk because R7's skin can get snagged on it.

On 01/31/24 at 12:42 PM, V22 (Regional Director of Maintenance) stated the Maintenance Department does monthly checks on resident wheelchairs to make sure they are working the way they are supposed to and to see if there were anything that would cause skin damage such as a broken piece of the equipment. V22 stated if Maintenance staff sees anything wrong or if there is safety concern with a wheelchair then that wheelchair would be taken off the floor right away until they were able to replace a broken/missing part or fix the problem. V22 stated arm cushions and arm rests can be replaced rather than having to replace the entire wheelchair assuming those replacement items are in stock. V22 stated if there is a problem with a resident's wheelchair in between the monthly monitoring they rely on the restorative staff to let them know so the issue can be addressed. V22 stated since V22 has been working at the facility for the past two weeks and no one has told V22 about any broken wheelchair or any wheelchairs that need to be replaced.

On 01/31/24 at 12:50 PM, V23 (Maintenance Assistant) stated when V23 is notified by the staff that there is a broken or missing part to a wheelchair V23 sees if V23 can fix the problem. V23 stated V23 has extra brakes V23 can use to replace on wheelchairs missing brakes or if the brakes are broken. At 12:51 PM, in the Maintenance Office/Storage Room observed V23 walk over to a cardboard box and pull out four wheelchair brakes to show the surveyor.

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 02/02/2024

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
S9999	Continued From page 6 Observed V23 walk over to a different cardboard box and pull out a new arm cushion wrapped in plastic. V23 stated here are the arm cushions, they come in two different sizes, large and small depending on the size of the wheelchair. V23 stated I also have extra arm rests which have arm cushion already attached which I can also replace as needed. V23 stated no one has asked me in the past two to three weeks to fix any residents brake on their wheelchair or replace any arm cushions or arm rests or given me a list of wheelchairs that need to be fixed. On 02/01/24 at 2:05 PM, V3 (Director of Nursing) someone should have noticed that R3's wheelchair was defective. V3 stated if you see something like that do something and naturally if a staff saw something like that someone should have seen it and acted on it. V3 stated damaged wheelchairs need to be removed right away so no one gets hurt. V3 stated we want to make sure we notice it and take care of it to prevent injuries with staff and residents. V3 stated, if this problem had been identified earlier then R3's accident potentially may have been prevented. R6 is a 64-year-old male, admitted to the facility 09/07/21 with diagnosis not limited to Unspecified Severe Protein-Calorie Malnutrition, Venous Insufficiency (Chronic) (Peripheral), Bipolar Disorder, Hereditary and Idiopathic Neuropathy, Idiopathic Hypotension, Adult Failure to Thrive, Type 2 Diabetes Mellitus with Other Circulatory Complications, Other Chronic Pancreatitis, Unspecified Psychosis Not Due to A Substance Or Known Physiological Condition, Nicotine Dependence. R6's MDS (Minimum Data Set) dated 11/03/23 documents 1.) BIMS (Brief Interview of Mental	S9999		

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 02/02/2024

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
S9999	Continued From page 7 Status) score of 14/15 indicating intact cognition, 2.) R6 uses wheelchair as mobility device, 3.) R6 requires partial/moderate assistance for chair/bed transfers. R6's Fall Risk Screen dated 05/04/23 documents in part, R6 is at moderate risk based on score of 13.0. R6's transfer and ambulation care plan dated 08/04/23 documents in part to lock wheelchair brakes. R7 is a 94-year-old male, admitted to the facility 06/14/17 with diagnosis not limited to Alzheimer's Disease, Polyosteoarthritis, Joint Disorder, Fracture of Shaft Of Left Humerus, Lack Of Coordination, Difficulty In Walking, Unspecified Symptoms And Signs Involving The Nervous System. R7's MDS (Minimum Data Set) dated 12/15/23 documents 1.) BIMS (Brief Interview of Mental Status) score of 00/15 indicating severe cognitive impairment, 2.) R7 uses wheelchair as mobility device, 3.) R7 requires substantial/maximal assistance for chair/bed transfers. Facility provided policy titled, Resident Rights - Accommodation of Needs and Preferences and Homelike Environment Policy dated 1/2024 documents in part, the facility will provide a safe environment. Facility provided document titled, "Preventative Maintenance Plan" dated 1/2024 documents in part, all resident rooms should be inspected for proper operation of all equipment. Facility provided Facility Assessment Tool dated 11/2023 documents in part maintenance team audits physical equipment and performs maintenance when necessary. Wheelchairs are listed as examples of physical equipment.	S9999		

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 02/02/2024

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
S9999	Continued From page 8 "B"	S9999		