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 03/25/2025

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 Investigation: 2581863/IL187552 Investigation of Facility Reported Incident of January 23rd, 2025/IL187639	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 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 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to prevent and protect two residents (R1, R5) from resident-to-resident abuse out of four	S9999		

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S9999	Continued From page 1	S9999		

residents reviewed for physical assault in a total sample of 14 residents. This failure resulted in R5 falling in the facility and sustaining a pneumothorax and several fractured ribs.

Findings include:

1.) On 03/18/2025, at 3:22 PM, R5 states herself and her former roommate (identified as R12) were arguing because R12 never cleaned and never showered. R5 states she was encouraging R12 to clean up and take a shower. R5 states R12 then told her to "shut the f**k up." R5 states she then told R12, "I'm not a kid, don't tell me to shut up." R5 states R12 then took a gray colored water pitcher with water inside and threw the water on R5. R5 states she tried to cover herself by placing her hands up over her face. R5 states in the process, she slipped on the water that R12 threw at her. R5 states she hit her chest when she fell. R5 states the facility called the ambulance and she was taken to the hospital and had broken ribs. R5 states she was moved to another room when she returned from the hospital. R5 states herself and her new roommate get along well without any problems. R5 states she sees R12 in the facility and has not had any other problems with R12 since then.

On 03/18/2025, at 3:30 PM, R12 states R5 was upset with her and wanted to argue. R12 states R5 had an attitude with her and wanted to fight. R12 states she threw water on R5 to calm her down. R12 states R5 slipped and fell over by the window and was taken out of the facility by the ambulance. R12 states herself and R5 are no longer roommates and when R5 returned from the hospital, R5 was moved to another room. R12 states she sees R5 in the facility but no longer speaks to R5.

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S9999	Continued From page 2 On 03/19/2025, at 1:39 PM, V8 (Licensed Practical Nurse/ LPN), states a CNA (Certified Nursing Assistant) came to notify her that R5 was moaning in pain and her left side was hurting. V8 states when she arrived to R5s' room, R5 informed her that she slipped, fell, and hit her side on the railing of her bed. V8 states R5 informed her that R5 fell on the previous shift. V8 states she asked R5 why R5 did not report it on the previous shift and R5 told V8 that R5 was not in pain then. V8 states she assessed R5 and R5s' side was red in color. V8 states she called the doctor and the Director of Nursing/DON (identified as V2) to notify them, but they did not pick up the phone. V8 states she then informed the supervisor on duty and the supervisor advised V8 to send R5 out to the hospital. V8 states she called the ambulance and sent R5 to the emergency room to be evaluated. V8 states she later was informed by V2 that V2 was made aware that R5 had a "squabble" with her former roommate (identified as R12). V8 states she was never informed by R5 that R5 was involved in an altercation with R12. V8 states she also informed V2 that V8 was not made aware of any altercations between R5 and R12. On 03/19/2025, at 3:18 PM, V2 (Director of Nursing/DON) states she was made aware by V8 (LPN) that R5 had a fall and was complaining of pain. V2 states R5 was then sent to the hospital to be evaluated. V2 states she was made aware via R5's hospital records that R5 reported that she slipped on water and fell in the facility. V2 states R5 did not originally report this to the facility. V2 states she then initiated an investigation for R5's fall. V2 states through her investigation, she was made aware that R5 and R12 had a disagreement about R5 making noise	S9999		

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	IL6001689	A. BUILDING: _____ B. WING _____	C 03/25/2025

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RYZE ON THE AVENUE	3400 SOUTH INDIANA CHICAGO, IL 60616

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S9999	Continued From page 3	S9999		

while R12 was trying to sleep. V2 states with further investigation, she was made aware that R12 alleged that R5 touched R12's shoulder. V2 states she informed V1 (Administrator) and V1 was responsible for following up with this allegation. V2 states she handles fall reportables (facility required documentation/report notifying the state surveying agency of an incident involving a resident) and V1 handles abuse reportables. V2 states she reported R5's fall to the state agency within the required time frame.

On 03/21//2025, at 9:12 AM, V1 (Administrator) states she is the abuse coordinator, and she was made aware by V2 (DON) of the altercation between R5 and R12. V1 states she spoke with R12 and R12 informed her that R5 hit R12 because R5 was making noise and R12 asked R5 to stop. V1 states R12 told V1 that R12 may have thrown some water near R5 and then sat back down on R12's bed and R12 "left it alone." V1 states she conducted an investigation and was made aware that R5 possibly slipped on some water. V1 states she spoke with R5 and R5 informed V1 that R12 threw water on R5. V1 states she was made aware that R5 may have fallen later after the altercation between R5 and R12. V1 states R5 did not use the verbiage that R5 fell on the water that R12 threw at R5. V1 states she reported this incident to the state agency within the required time frame.

R5's Face sheet documents that R5 has diagnoses not limited to: Multiple fractures of ribs, left side, subsequent encounter for fracture with routine healing, traumatic hemopneumothorax, subsequent encounter, unspecified fall, sequela, and vitamin D deficiency.

R5's MDS/Minimum Data Set dated 12/17/2024,

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RYZE ON THE AVENUE	3400 SOUTH INDIANA CHICAGO, IL 60616

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S9999	Continued From page 4	S9999		

documents that R5 has a BIMS/Brief Interview for Mental Status of 9/15, indicating that R5 is moderately cognitively impaired. R5 requires substantial/maximum assistance with ADL/Activities of Daily Living care. R5 is incontinent of bladder and bowel. R5 ambulates via walker.

R5's care plan dated 03/10/2025. documents "R5 has 4th/6th rib Fracture r/t Fall. R5 had a traumatic hemopneumothorax." R5s' care plan dated 03/11/2025 documents "Encourage resident to report all spills to staff immediately." R5s' care plan also documents that R5 is at high risk for falls.

R5's hospital records dated 03/07/2025, documents that R5 has diagnoses of "small left pneumothorax, acute, displaced fracture of the left fourth and sixth through ninth ribs." R5 was admitted to the hospital on 03/02/2025, due to bleeding and chest injury.

R12's Face sheet documents that R12 has diagnoses not limited to: unspecified dementia, cerebral infarction, type 2 diabetes mellitus, essential hypertension, and chronic viral hepatitis C.

R12's MDS/Minimum Data Set dated 02/07/2025, R12 has a BIMS/Brief Interview for Mental Status of 13/15, indicating that R12 is cognitively intact. R12 requires supervision assistance with ADL/Activities of Daily Living care. R12 is incontinent of bladder and bowel and ambulates via walking.

R12's behavior assessment dated 03/06/2025 documents that R12 was physically aggressive towards her roommate (identified as R5).

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	IL6001689	A. BUILDING: _____ B. WING _____	C 03/25/2025

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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S9999	Continued From page 5	S9999		

Nursing progress note dated 03/02/2025, written by V8 (LPN) at 5:13 AM, documents "R5 explains to writer that she had a fall on the previous shift and is screaming in severe pain in her left side ribs. R5 says that it hurts when she tries to move. Supervisor was notified and suggested to send R5 out to hospital for further evaluation."

Nursing progress note dated 03/02/2025, at 6:15 PM documents "R5 admitted to hospital with admitting diagnosis trauma, multiple rib fractures."

Record review documents that R5 resided in the same as R12 on 03/02/2025.

Ombudsman Residents' Rights for People in Long-Term Care Facilities dated 11/2028 documents in part, "You must not be abused, neglected, or exploited by anyone - financially, physically, verbally, mentally, or sexually."

2.) According to R1's face sheet and MDS 2/28/25 provided by facility, R1 has diagnoses that include but not limited to Alzheimer's disease, anxiety disorder. R1 has a BIMS (Brief Interview for Mental Status) score of 6 indicating severe cognitive impairment and required services of and resided on a specialized dementia/Alzheimer unit.

According to R1's care plan provided by facility, R1 is care planned for wandering behavior: R1 demonstrates behavior that may be interpreted as wandering, pacing, or roaming related to the diagnosis of Alzheimer's disease. Symptoms are manifested by pacing, roaming, or wandering in and out of peer's rooms. R1 is care planned for abuse/neglect: R1's comprehensive assessment

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	IL6001689	A. BUILDING: _____ B. WING _____	C 03/25/2025

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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S9999	Continued From page 6	S9999		

reveals a history of suspected abuse and/or neglect or factors that may increase his/her susceptibility to abuse/neglect. R1 is care planned for Alzheimer: R1 has diagnosis of Alzheimer's and may display moods/behaviors related to diagnosis such as agitation/aggression.

According to R2's face sheet and MDS 1/3/2025, provided by facility, R2 has diagnoses that include but not limited to schizophrenia, restlessness and agitation, type 2 diabetes mellitus. R2 has a BIMS (Brief Interview for Mental Status) score of 13 indicating intact cognition.

According to R2 care plan provided by facility, R2 is care planned for behavior: R2 has a history of verbal and physical aggression and threatening staff and peers. The resident has a diagnosis of schizophrenia.

On 3/18/25 at 2:50 PM, V25 (Certified Nursing Assistant/CNA) stated V25 heard a scream from R1. I went to see what was going on. This happened in R2's room. When I went into the room there was a CNA (V26) in the room who was trying to get R1 and R2 apart. R2 was in a wheelchair. R1 was standing. R2 had the wheelchair armrest in hand and was hitting R1 in the head with it. R1 wanders in different resident rooms and is known to lay down in their beds.

On 3/18/25 at 3:00 PM, V26 (CNA) stated V26 was walking past R2's room and heard R1 saying "Stop". I went into the room and saw R2 hitting R1 with an object. R2 did make contact with R1. I immediately called for the nurse. I stood in between them. R2 was in a wheelchair. R1 was standing in R2's room. R1 is a wanderer. I believe R1 went out to the hospital. R2 went out

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	IL6001689	A. BUILDING: _____ B. WING _____	C 03/25/2025

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RYZE ON THE AVENUE	3400 SOUTH INDIANA CHICAGO, IL 60616

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S9999	Continued From page 7	S9999		

to the hospital and has not been back to the facility. R1 gets confused, tired and wants to sit down. It is typical for R1 to wander into other residents' rooms. R2 is mean and grumpy. R2 has outburst cursing at staff. R1 has dementia.

On 3/18/25 at 3:13 PM, V4 (Licensed Practical Nurse/LPN) stated R1 went into R2's room. R1 wanders. R1 started yelling. The CNA called out for help. Me and another nurse went into the room and separated R1 and R2. R2 can be irate. R2 is combative, was always yelling, mean and mad. It was a challenge to give R2 care. R2 mostly yelled and cursed at staff. R2 had the cushion from the wheelchair armrest in hand. I sent R1 and R2 to the hospital. R2 was sent for a psychiatric evaluation. R1 went to the hospital because R1 had redness/abrasion on the forehead and a scratch. I notified the physician, family, and the Director of Nursing. The administrator is the abuse coordinator. I have had abuse in-services within the last month. If I witness abuse I would intervene, separate the residents, and notify the administrator.

On 3/21/25 at 12:30 PM, V12 (LPN) stated I was called to the situation. I helped separate the two (R1 and R2). I was at the other end of the unit/floor. I heard the commotion, the CNA yelled for me and said R1 is in the room having an incident with R2. I went to the room. R1 was already out of the room and R2 was wheeling himself to the door to come out of the room saying, "R1 was in my room". I stepped in between and closed the door so R2 could not come out. I did not see anything in R2's hands. I monitored R2 until R2 was petitioned out to the hospital. R1 roams a lot, and I have not observed any aggressive behaviors. R2 has random outbursts if someone comes in R2's

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	IL6001689	A. BUILDING: _____ B. WING _____	C 03/25/2025

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RYZE ON THE AVENUE	3400 SOUTH INDIANA CHICAGO, IL 60616

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S9999	Continued From page 8	S9999		

space/personal space. R2 has said "Get away from me". R2 is mostly into himself.

On 3/21/25 at 2:40 PM, V1 (Administrator) stated I am the abuse coordinator. I was the Administrator/abuse coordinator at the time of the incident with R1 and R2, on 1/23/25. The last abuse in-service was in 2/25/2025. Some types or abuse are physical, neglect, mental, involuntary seclusion, exploitation, financial. My expectation is for abuse to be reported to me immediately. Residents should be separated immediately. The incident with R1 and R2 was reported to me and my assistant administrator at that time. It was alleged that R2 was agitated and allegedly hit R1. The nurse, V4 (Licensed Practical Nurse), told me that when she went into the room R2 was swinging at R1. V4 said R2 had the cushion from the arm rest in hand. V4 said they immediately separated them and both residents were assessed. There were no injuries observed. Abuse was not substantiated due to the evidence. R1 and R2 were both sent to the hospital for evaluation. R1 came back from the hospital. R2 has not been back since the incident and is not returning. R2 stated R2 does not want to come back to the facility.

R2 nursing progress note, 1/23/2025, 11:35 AM, reads in part: resident made physical contact with another resident. Resident stated, " Resident entered my room and would not get out." Separated resident from other resident and monitored resident behavior. Resident sent to hospital for psych evaluation and treatment. MD (medical doctor) and family notified of incident and transfer.

State Report of Abuse Allegation, 1/23/25, reads in part: R1, R2 and staff were interviewed related

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S9999	Continued From page 9	S9999		

to the resident-to-resident altercation that occurred. Upon investigation, it was determined that R2 allegedly hit R1 in the forehead although the incident was unwitnessed. Residents were immediately separated to prevent further conflicts and ensure the safety of all residents. R2 was educated on the appropriate procedures for reporting concerns, emphasizing the importance of notifying staff rather than taking matters into their own hands. Both residents were sent out to the hospital for further evaluation. R2 has not returned to the facility at this time. A police report was filed. Alleged victim (R1) orientation is not alert with a diagnosis of Alzheimer's disease. Alleged perpetrator (R2) orientation is alert with a diagnosis of schizophrenia.

Facility Abuse Policy and Prevention Program, 10/20/22, reads in part: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation or property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident. Physical abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment.

"A"

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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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