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 04/23/2025

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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S 000	Initial Comments Investigation of Facility Reported Incident of February 3, 2025/IL190194 Investigation of Facility Reported Incident of March 30, 2025/IL190449	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental	S9999		

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and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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 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:

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Based on observation, interview, and record review the facility failed to accurately assess or evaluate a resident that are high risk for falls, failed to provide plan of care for falls. The facility failed to ensure fall preventive measures or interventions were implemented. The facility also failed to monitor and supervise a resident to prevent falls for 1 (R1) out of 3 residents reviewed for fall prevention program. These failures resulted in R1 falling twice. R1's first fall resulted in R1 being admitted to the hospital with an epidural brain bleed. R1's second fall resulted in R1 sustaining a laceration to the back of his head.

Finding includes:

R1 is 72 years old, re-admitted in the facility on 01/07/2025 with repeated falls and traumatic subdural hemorrhage and coagulation defect. Clinical notes of R1 dated 02/03/2025 by V11 (Registered Nurse/RN) documents that R1 was seen on laying on the floor. R1 stated that he hit the back of his head. R1 was transferred to the hospital with admitting diagnosis of epidural brain bleed per V24 (Licensed Practical Nurse/LPN). On 03/18/2025 R1 fell again sustaining a laceration at the back of his head. R1 was transferred to the hospital, currently not in the facility.

On 04/16/2025 at 12:09 PM V11 (RN) stated that she worked from 07:00 AM to 03:00 PM the day R1 fell on 02/03/2025. V11 stated that it was a CNA (Certified Nursing Assistant) that informed her that R1 was on the floor. V11 said, "It was an unwitnessed fall." V11 said that R1 does not ambulate, non-compliant to instruction. R1 wants to try to do things that he cannot do. He needs

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assistance when getting up and needs 1-to-2-person assistance. V11 stated that it was around breakfast time when R1 fell. V11 stated breakfast starts at 07:30 AM and during that time, R1 ate breakfast in bed. V11 stated that she did not see anyone feed R1. V11 was asked if it would be safer for R1 to be transferred to the wheelchair and monitor by staff instead of leaving R1 in his room alone. V11 stated "I am not sure if it will prevent R1 from falling." V11 stated that R1 was not transferred to his wheelchair because he is not on the get up list. V11 stated it would be hard for CNAs who are busy feeding another resident to come wash up R1 and place R1 in a wheelchair.

On 04/16/2025 at 1:52 PM, V2 (Director of Nursing/DON) stated R1 kept saying he can walk, and he tries to maintain his independence. R1 was not on the get up list and was not scheduled to get up. Reviewed R1's care plan with V2. R1's fall care plan does not have any fall prevention interventions prior to the fall and was created on 02/03/2025. R1's fall care plan interventions are as follows: Encourage R1 to ask for assistance before transferring created on 2/11/2025, floor mat in place created date 03/18/2025, R1 will receive education related to potential fall risk and preventative measures created 02/10/2025. Per statement by nursing staff, R1 is non-compliant with instruction. R1 insist he can walk does not follow redirection. V2 was asked, how can these interventions help prevent R1 from falling? V2 stated "the problem was that he got up without assistance." V2 was asked about the investigation she conducted. V2 was asked if the nursing staff, both nurses, and certified nursing assistants' whereabouts were accounted for. V2 replied, "In doing our investigation we don't asked nursing staff where they are at the time of the fall

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or during the fall." V22 (CNA) that was assigned to R1 does not have written statement as part of investigation. V2 was informed that R1 fell again inside his room on 03/18/2025 sustaining laceration on the back of his head with bleeding. V2 replied, "I have to look at the records." V2 stated that other interventions can prevent fall of R1, like putting signage or placing R1 in the get up list.

On 04/22/2025 at 11:38 AM V7 (LPN) verified that she was the nurse on the day R1 fell on 03/18/2025. V7 stated that R1 was trying to get in his wheelchair when he fell. V7 stated that none of the staff was in the room. None of the staff witnessed the fall of R1. R1 had bleeding on the middle area of his head. V7 stated it happened around 08:00 PM as it was noted in her notes.

R1's assessment for admission dated 01/07/2025 and re-admission dated 02/17/2025 documents that R1 is at high risk for fall with score of 16 on 01/07/2025. R1's score increased to 20 on 02/17/2025. Per assessment instructions, any score above 10 considered as high risk for falls. Although both assessments have scores higher than 10, staff who assessed put the score of 8 on both assessments indicating that R1 is not high fall risk. There was no baseline care plan intervention provided on both assessments.

On 04/22/2025 at 10:18 AM, reviewed R1 fall assessments, evaluations and fall care plans with V25 (Restorative Nurse/LPN) and V26 (Restorative Nurse/LPN). V25 stated that the number or score is wrong on R1's fall assessment included during admission evaluation dated 01/07/2025 (prior to fall) and 02/17/2025 (after to fall). V25 stated that the score eight (8) represent the number of items being answered,

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not the score based on fall assessment. Per fall assessment ten (10) and above means high risk of fall. R1's score should be sixteen (16) for the assessment dated 01/07/2025 which is a high risk of fall. R1's score for the fall assessment dated 02/17/2025 should have been scored 20 which is high risk for fall. V25 was made aware that there was no baseline plan of care intervention for all fall assessments of R1. Upon reviewing the care plan, V25 stated that R1 does not have any fall care plan prior to fall. V25 said, "Nothing on 01/07/2025 care plan for fall." V25 and V26 made aware on their policy fall assessment/evaluation and fall care plan review should be done during admission and quarterly to prevent resident from falling. R1 does not have fall interventions upon admission dated 01/07/2025 although he came in the facility with history of falls.

On 04/23/2025 at 09:44 AM, V2 (Director of Nursing) was made aware of concerns related to R1 fall assessments/evaluations and lack of care plan interventions prior to falls. V2 stated that it will help prevent fall for R1 if there were interventions placed prior to the falls. V2 said, "I cannot say that all falls can be prevented. But interventions prior to fall may help prevent falls."

Fall Prevention and Management policy dated 02/2025 reads: This facility is committed to maximizing each resident's physical, mental and psychosocial well-being. The facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible. All resident falls shall be reviewed, and the resident's existing plan of care shall be evaluated and modified as needed. All fall risk evaluation will be completed on admission, readmission, and quarterly, significant

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S9999	Continued From page 6 change and after each fall. A fall risk evaluation is completed by the Nurse. A score of 10 or greater indicates the resident is at "high risk" for falls; a score of less than 10 indicates "at risk" for fall. Care plan to be updated with new intervention based on root cause analysis after each fall occurrence. "A"	S9999		