STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145337	A. Building B. Wing	06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ryze on the Avenue	3400 South Indiana Chicago, IL 60616

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect residents' rights to be from physical abuse from another resident. This failure affects two (R4, R5) residents out of five residents reviewed for abuse in a total sample of 14. As a result of this failure, R5 hit R4 in the head on 02/27/2026 resulting in R4 sustaining a laceration to his head and being sent to the hospital. As a result of this failure, R4 hit R5 in the face on 02/27/2026 resulting in R5 sustaining a closed nasal bone fracture and being sent to the hospital.Findings include: Facility reported incident/FRI dated 02/27/2026, documents that the facility reported an altercation between R4 and R5. The FRI documents that R4 was noted with a laceration to his head. R4 stated that he had his remote control in his hand and threw it towards R5. R5 returned to the facility from the hospital, and review of hospital documentation indicated that a CT (computed tomography) scan identified a closed nasal bone fracture. On 06/12/2026 at 3:16 PM, R5 was lying on his bed, alert, responsive, and in no apparent distress. R5 stated (R5) went into someone's washroom, and he (R4) told me I couldn't use it. I asked him why not. R5 stated that they kept talking, and he (R4) hit me first with the television remote. I got mad and I (R5) hit him with my fist. I (R5) hit him on the head. Then somebody came and asked what we were doing. I (R5) went to my room. R5 stated that he went to use R4's bathroom because someone was using R5's bathroom. R5 stated I had to go bad, and it was next door's bathroom. R5 denied that he had a broken nose prior to the altercation. R5 stated that they told him at the hospital that he had a broken nose. R5 stated that R4 kept hitting R5 more than once with an item. R5 stated that it hurt R5's head when R4 hit R5.On 6/12/2026 at 6:17 PM, V1 (Administrator) stated I've been at the facility since September 2025. I am the abuse coordinator. R5 stated he had to use the restroom and that he went to the room of R4 because R5 was trying to get to the bathroom in a hurry. R4 was telling R5 not to use their restroom in their room. R4 and R5 got into a disagreement. V20 (Certified Nursing Assistant/CNA) heard R4 and R5 going back and forth. V20 entered the room to separate R4 and R5. V20 got the nurse to come to the room. R5 grabbed a water pitcher from R4's table and was trying to swing. R4 was trying to block the swing. V19 (Licensed Practical Nurse/LPN) noted that R4 was bleeding from the left side of his head. The NP (Nurse Practitioner) ordered for R4 to go out 911. R5 was sent out for psych evaluation. The hospital did not report the fracture to the facility. We found out from the paperwork. There were no witnesses in the room. Residents have the right to be free from abuse.On 6/15/2026 at 10:29 AM, V19 (LPN) stated she was the nurse for both R4 and R5 when the incident happened. V19 stated she was at the nursing station. The CNA, V19 does not remember which CNA, yelled out for the nurse. V19 went to R4's room. V19 saw R4 in the wheelchair and R5 was standing. The CNA was between R4 and R5. The CNA did not know what happened between R4 and R5. I asked R5 to leave the room. I asked R4 what happened. R4 said R5 was trying to use R4's washroom and R4 said no. R4 was bleeding but I could not tell from where because of R4's hair. The blood was on the left side of R4's forehead. The blood was not dry; it was new blood. I got a verbal order from the NP (Nurse Practitioner) to send R4 out 911. I assessed R5. R5 was upset. R5 had a small amount of blood in his nose but it was not actively leaking. The blood was new because it was (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	not there prior when I saw R5. I could not get R5 to stay in his room, separated from other residents, which is protocol. I got orders to send R5 out for a psychiatric evaluation. On 06/15/2026 at 8:33 AM and at 11:48 AM, attempted to outreach V20 (Certified Nursing Assistant), the CNA who heard the altercation between R4 and R5, with no answer. Left a voicemail message. On 06/15/2026 at 3:15 PM, V36 (R4's and R5's Nurse Practitioner) asked if they could return the call. No call returned prior to the survey exit. R5's face sheet documents that R5's diagnoses include but not limited to: cerebral infarction due to unspecified occlusion or stenosis of left middle cerebral artery, hemiplegia and hemiparesis following cerebrovascular disease affecting unspecified side. R5's MDS/Minimum Data Set, dated [DATE], documents that R5 has a BIMS/Brief Interview for Mental Status score of 13/15, indicating that R5 has intact cognition function (with no or very little impairment). R5's progress notes dated 2/27/2026, by V19 (Licensed Practical Nurse) documents R5 was noted to have blood in the left nostril. R5 was sent to the hospital for psych eval. Hospital records dated 2/27/2026, documents R5 sustained nasal bone fracture. Abuse care plan reads R5 was involved in a resident-to-resident altercation. R4's face sheet documents R4's diagnoses includes but not limited to: discitis, unspecified, thoracic region, chronic obstructive pulmonary disease, type 2 diabetes mellitus, psychoactive substance abuse. R4's MDS/Minimum Data Set, dated [DATE], documents that R4 has a BIMS/Brief Interview for Mental Status score of 15/15, indicating that R4 has intact cognition function (with no or very little impairment). R4's progress notes dated 2/27/2026, by V19 (LPN) documents R4 had active bleeding on the left side of the head following altercation with another resident. R4 was sent to the hospital via 911. R4's abuse risk care plan documents that resident (R4) is a victim of resident-to-resident altercation dated 2/27/2026. Hospital record documents that R4 was evaluated for an injury of the head. Facility document dated 10-2022 documents in part, abuse policy and prevention program. 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. 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.