STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146132	A. Building B. Wing	09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ryze at Homewood	19000 South Halsted Homewood, IL 60430

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 Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(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 Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to keep two residents (R3 and R5) free from resident-to-resident physical abuse after R3 was punched in the right eye by another resident (R4), and R5 was slapped on the head by another resident (R1) for two out of five residents reviewed for abuse in a total sample of nine. This failure resulted in R3 sustaining blunt head trauma and a swollen, black eye.Findings Include:1.R3 is a [AGE] year-old female resident admitted in the facility on 5/1/2024. R3 is assessed to be alert, able to make needs known, forgetful at times.R4 is a [AGE] year-old male resident admitted in the facility on 7/8/2025.On 9/16/2025 at 12:07 PM, R3 observed in her room lying in bed. R3 was able to answer questions appropriately, but noted forgetful at times. There was slight purplish discoloration around the right eye observed. R3 was able to remember there was a guy who punched her hard on the face.On 9/16/2025 at 12:10 PM, R3 stated she remembers there was a guy who hurt her on the face. R3 stated R4 punched me hard on the face and was kind of hard while I was standing in the kitchen. It hurt me right here pointing to the right side of her face. R3 stated she feels safe here.On 9/17/2025 at 11:39 AM, V2 (Social Service Director) stated, If the residents are assessed to be at risk for abuse, then they need to be protected. The care plan should be put in place with interventions to prevent abuse. When V2 was asked about the incident that led to R3's injury on 8/25/2025, V2 stated she was not in the facility at that time, but the incident was physical abuse. V2 stated R3 should have been immediately removed from the area and should have been frequently monitored. V2 agreed R3 should have been protected.During a telephone interview on 9/18/2025 at 10:44 am, V8 (Activity aide) stated she was present and was doing pumpkin faces activity in the dining room with residents when the incident happened on 8/25/2025. V8 said she was paying attention to the crafts the residents were doing at that time. There were a lot of people in the room, and music was playing. R3 and R4 were both sitting in the same table across each other. V8 said she was the only activity aide present at the time. V8 said she did not witness the whole incident. V8 said she just saw in her periphery when R4 was coming towards R3, and it was quick and fast. V8 said R4 hit R3, and it was fast. V8 said they disengaged them after the incident and took R3 to the nursing station.On 9/18/2025 at 12:07 PM, V1 (Administrator) stated she is the one who investigated and sent the final report of the incident to IDPH (Illinois Department of Public Health). V1 stated R3 and R4 were both in the activity room when the incident happened on 8/25/2025. R4 was sitting on the opposite side of the table from R3. R4 got up and swung at R3 and hit R3 on the side of her face. The activity aide was sitting right next to R3, the activity aide reported, (R4) was coming towards (R3) so she went to get (R3), but she couldn't grab (R3). (R4) was still able to swing at her and hit her on the side of her face. There was only 1 activity aide at that time. V1 stated, (R4) was very upset and ranting at that time, and we did not know what he is ranting about. V1 also stated R4 was so irritated and not redirectable so the facility had to petition him out, and R4 left the following day. V1 also said they reported it to (local) Police department.R3's Social service care plan on Abuse, initiated on 6/11/2024 states that R3 may be At risk for abuse due to confusion, memory loss, wandering and lack of safety awareness. R3's care plan goal on abuse sates that R3 will be free of abuse/neglect daily through next review.R4's Social service care plan on Abuse, initiated on 7/9/2025 states R4 is At risk for abuse. R4's care plan goal states, Staff will monitor well-being of others. Resident will have zero episodes of abuse and neglect throughout next review.On 8/25/2025, Nursing notes states R3 was sent out to the emergency department (ED) for further treatment after R4 struck her on the face. ED report stated, (R3) had blunt head trauma resulting to right eye blunt injury after being assaulted by another resident.On 8/27/2025' Nurse Practitioner's subsequent visit notes states R3 was recently seen at an acute care hospital on 8/25/25 and returned back to facility on 8/26/25 for Blunt Head Trauma. Blunt head trauma was sustained by another demented resident that punched her in the right side of her face. R3 was transferred to the Emergency Department immediately afterwards and underwent a Computed Tomography (CT) scan of facial bones and Head CT, both without contrast and both resulted negative for acute changes.This incident was reported by R3's daughter to (local) Police Department (H25-14043). The police report stated R3's daughter said she was notified by the facility on 8/25/2025 that R3 was involved in a battery and was transferred to the hospital via private ambulance. R3's daughter said she noticed R3 had sustained a swollen, black eye.R3's facility reported abuse incident to IDPH, dated 9/2/2025, states R3 was struck on the face by R4. The final report stated R4 abruptly walked around the table and swung at R3 before staff could intervene. R4 struck her on the right side of her face. R3