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	12/31/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately complete Fall Assessments for four residents (R1, R6, R7 and R8), who have a history of falling. This failure has the potential to affect four residents (R1, R6, R7 and R8) in a sample of six residents (R1, R4, R5 R6, R7 and R8) reviewed for falls.Findings include: 1.R1 no longer resides at the facility. R1 expired on [DATE].R1's face sheet documents diagnoses that include but not limited to hypertension, metabolic encephalopathy, osteomyelitis of vertebra, type 2 diabetes, acute respiratory failure with hypoxia, acquired absence of left leg below the knee, quadriplegia, acute kidney failure, and sepsis.R1's BIMS (Brief Interview Mental Status) score, per admission note dated [DATE], documents a BIMS score of 9, which indicates R1's cognition is moderately impaired.Facility document titled, Incidents by Incidents Type, dated [DATE], documents R1's fall occurred on [DATE] at 8:30pm.R1's progress note, dated [DATE] at 1:09am, per V14 (Registered Nurse/RN), documents, The writer upon getting to the resident (R1's) room to pass the pm medication, the resident was found on the floor with the head on the floor and the lower part of the body on the bed. The resident is unable to give the description. The resident helped back to the bed. Head to toe assessment completed. alert and responsive. no visible injury noted. no change in the range of motion, no change in the mental status, V/S (vital signs) WNL (within normal limits). The MDS (Minimum Data Set) nurse informed, unable to reach the MD (medical doctor) on phone, message left. Guardian notified, safety measures in place.R1's Fall Risk Assessment, dated [DATE], documents, 3. Predisposing Conditions: 0. None; 7. Falls, Accidents, Fractures: 0. None. R1 has a documented diagnosis of hypertension, which should have been scored as a 2 rather than 0. In addition, R1 experienced a fall on [DATE], and a score of 10 should have been recorded, as the current fall must be included in the assessment.2.R6's face sheet documents diagnoses that include but are not limited to history of falling, fracture of shaft of right humerus, and pneumonia.R6's BIMS (brief interview mental status) score, dated [DATE], is 14, which indicates R6 is cognitively intact.On [DATE] at 1:15pm, R6 said, I'm good here (facility). When I fell ([DATE]), my body was just too heavy for my legs. No, it was my fault. I didn't use my light. It wasn't a bad fall. They told me to use it. Now, before I came, my fall was bad. It (fall prior to admission to facility) was [DATE]. I will never forget it. It was like BOOM! I hollered for help. That's why I have my arm in this sling.R6's physician order, ordered date [DATE], documents, Senna-S Tablet 8.6-50 MG (Sennosides-Docusate Sodium): Give 1 tablet by mouth two times a day for Constipation.R6 Clinical Overview, dated [DATE], documents, [AGE] year-old male transferred after a traumatic fall from ground level resulting in a right humeral fracture.R6's progress noted, dated [DATE], documents, Writer alerted by CNA (Certified Nursing Assistant) that resident (R6) was lowered to ground during transfer. Resident stated, I was too heavy, and she helped get on the floor so that I didn't fall. Assisted from floor to wheelchair, head to toe assessment complete with 0 abnormalities, denies pain and exhibits 0 nonverbal s/s (signs and symptoms) of pain.R6's Fall Risk Evaluation, dated [DATE], documents, 7. Falls, Accidents, Fractures: 0. None; 9. Medications: 0. None. This assessment is inaccurate because R6 had a documented previous fall (before arriving to facility) prior to the fall of [DATE], and a score of 10 should have been recorded, as the previous fall and the current fall must be included in the assessment. In addition, R6 receives the medication Senna-S, and a score of 2 should have been recorded, as the medication Senna-S increases GI (gastrointestinal) motility.3.R7's face sheet documents diagnoses that include but are not limited to history of falling, Parkinson's disease without dyskinesia, epilepsy, and dementia.R7's BIMS (Brief Interview Mental Status) score, dated [DATE], is 00, which indicates R7 has severe cognitive impairment.R7's progress note, dated [DATE], documents, Resident (R7) walking out of the dining room, stated she had to use the bathroom. Resident has Parkinson's and tripped and fell hitting the front of her head on the floor and got right back up and started walking again to the bedroom.R7's care plan, dated [DATE], documents, (R7) is HIGH risk for falls r/t (related to) Gait/balance problems. R7's care plan, dated [DATE], documents, Restorative Program: (R7) requires practice in walking due to shuffling gait and Parkinsonism.R7's Fall Risk Assessment, dated [DATE], documents, 2. Mobility: 0. Independent mobility with STEADY GAIT. R7 does not have a steady gait as documented in R7's care plan, which should have been scored as a 3 rather than 0.4.R8's face sheet documents diagnoses that include but are not limited to cerebral infarction and seizures.R8's BIMS (Brief Interview Mental Status) score, dated [DATE], is 8, which indicates R8 has moderate cognitive impairment.R8's progress note, dated [DATE], documents, Upon writer arrived at the facility it was reported

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on interview and record review, the facility failed to notify the physician of an unwitnessed fall with potential head injury affecting one resident (R1) and failed to properly in-service staff on the Fall Risk Assessments. These failures affected one resident (R1) reviewed for falls and has the potential to affect all the residents residing at the facility. Findings include:Facility census, dated 12/08/25, documents 129 residents residing at the facility.Record review of CMS's RAI (Resident Assessment Instrument) Chapter 3 Item (J), dated October 2024, documents, Falls are a leading cause of injury, morbidity, and mortality in older adults. A previous fall, especially a recent fall, recurrent falls, and falls with significant injury are the most important predictors of risk for future falls and injurious falls. Identification of residents who are at high risk of falling is a top priority for care planning. A previous fall is the most important predictor of risk for future falls. The fall may be witnessed, reported by the resident or an observer or identified when a resident is found on the floor or ground.R1's face sheet documents an admission date of 9/29/2025.R1's face sheet documents diagnoses that include but not limited to hypertension, metabolic encephalopathy, osteomyelitis of vertebra, type 2 diabetes, acute respiratory failure with hypoxia, acquired absence of left leg below the knee, quadriplegia, acute kidney failure, and sepsis.R1's BIMS (Brief Interview for Mental Status) score, dated 9/30/25, documents a BIMS score of 9, which indicates R1's cognition is moderately impaired.Facility document titled, Incidents by Incidents Type, dated 12/08/2025, documents R1's fall occurred on 10/04/2025 at 8:30pm.R1's progress note, dated 10/05/2025 at 1:09am, per V14 (Registered Nurse/RN), documents, The writer upon getting to the resident (R1's) room to pass the pm medication, the resident was found on the floor with the head on the floor and the lower part of the body on the bed. The resident is unable to give the description. The resident helped back to the bed. Head to toe assessment completed. alert and responsive. no visible injury noted. no change in the range of motion, no change in the mental status, V/S (vital signs) WNL (within normal limits). The MDS (Minimum Data Set) nurse informed, unable to reach the MD (medical doctor) on phone, message left. Guardian notified, safety measures in place.R1's progress note, 10/05/2025 at 10:10pm, per V7 (Registered Nurse/RN), documents, Writer entered patient's (R1) room to render care, and he was hard to arouse, sternal rub done with no reaction. Writer unable to palpate a radial or carotid pulse. B/P (blood pressure) cuff placed on patient with a reading of B/P 69/25, HR 83, no rise or fall of chest noted, writer remained unable to palpate a manual pulse. Full code status confirmed, and code blue was called. Chest compression began immediately. 911 called, crash cart brought in room and AED (automated external defibrillator) applied, no shock was advised. Support staff arrived chest compression continued, rescue breaths delivered via Ambu bag on 10/l (liters) of oxygen. AED analyzed patient x3 prior to fire department's arrival and no shock was advised.R1's progress note, 10/05/2025 at 10:17pm, per V7 (Registered Nurse/RN), documents, Fire department crew arrived, and resuscitative efforts were transitioned over to fire department crew, patient remained pulseless upon transfer of care to the fire department.R1's progress note, 10/05/2025 at 10:25pm, per V7 (Registered Nurse/RN), documents, Resuscitative efforts ceased by fire department and patient time of death called at 10:25pm.R1's Fall Risk Evaluation, dated 10/05/2025, documents a score of 10, indicating R1 is at high risk for falling.R1's progress note, service date 10/03/2025, Acute Weakness/Debility: fall precautions, PT/OT (Physical Therapy/Occupational Therapy). R1's care plan, dated 9/29/2025, documents, FALL: Resident (R1) is at high risk for falls, with interventions that document, Notify MD and family of any new fall.On 12/08/2025 at 12:59pm, V14 (Registered Nurse/RN) said, Yes, I am familiar with (R1). I was working when he fell. I walked into the room to pass medications and found him on the floor, with his head on the floor and part of his body hanging off the bed. The CNA (Certified Nursing Assistant) and I assisted him back into bed. I cannot remember which CNA. I completed the assessment and noted no injuries and no changes in mental status. I obtained his vital signs and blood sugar. I provided him with food and administered his medications. He did not complain of any pain. I did not speak directly with the physician, but I left a message. I cannot remember the physician's name, but it was the primary doctor for Unit 5. I called V2 (Director of Nursing/DON) too. According to protocol, when a fall is unwitnessed, the resident is typically sent to the hospital; however, if the resident is not on a blood thinner, we (facility staff) monitor vital signs every 15 minutes for the first hour and continue per protocol. I'm not sure if there is a written policy on this. We have a separate book designated for neuro checks. I monitored the resident throughout my shift, and he remained stable, which continues for 72 hours. I called the doctor once and left a message. I did not call back because there were no changes in the resident's condition.On

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 have a system in place to monitor and investigate how a resident with a history of drug usage was able to obtain illicit drugs in the facility. This failure affected one (R3) of three residents reviewed for supervision. As a result of this failure, R3, who did not have an independent outside pass privilege, tested positive for illicit drugs on 9/19/25, 9/25/25, and 10/3/25, requiring transfer to local hospital.The Immediate Jeopardy began on 9/19/25 when R3 was sent to the hospital and tested positive for illicit drugs while in the facility. V1 (Administrator) was notified on 12/23/25 at 1:38 PM of the Immediate Jeopardy.The surveyor confirmed by interview and record review the Immediate Jeopardy was removed on 12/30/25, but noncompliance remains at level two because additional time is needed to evaluate the implementation and effectiveness of the in-service training.Findings include:R3 is [AGE] years of age. Current diagnoses include but are not limited to Chronic Obstructive Pulmonary Disease, Asthma, and Chronic Kidney Disease. R3 has a known history of substance abuse. R3's comprehensive assessment section C cognitive status, dated 9/9/2025, documents a Brief Interview for Mental Status score of 15, indicating R3 is cognitively intact.R3 was admitted to the facility on [DATE]. R3 was discharged to the hospital due to chest pain on 10/03/25 and no longer resides in the facility. R3's nursing progress notes from 9/19/25 and 9/25/25 document staff finding a white powered substance and a crack pipe in R3's room. R3's hospital records from 9/19/25 and 9/25/25 both document R3 admitted to using cocaine in the facility. The hospital urine drug screen indicates he was positive for cocaine.R3 was hospitalized on [DATE] for chest pain. While hospitalized on [DATE], his urine drug test concluded positive for cocaine, fentanyl, and opiates. Per hospital records, when R3 arrived at the hospital, the floor the nurse found cocaine and pipes in his pocket.On 9/18/25 at 7:57 PM, V10, RN/Registered Nurse, documented R3 observed in room with increased confusion and aggressive behavior. Nurse practitioner and DON/Director of Nursing made aware. New order for UA (urinalysis).On 9/18/25 at 8:13 PM, V38, NP, note states: Patient seen for initial visit. Patient was seen after nursing report he was extremely agitated and was hitting the walls and bed. He then wheeled out in halls agitated and yelling. Discussed with patient and he reports this happened in the past, had hallucinations with UTI (urinary tract infection). Will have nursing obtain U/A (urinalysis) for further evaluation. Social history: history of substance abuse, crack cocaine, and heroin use. Physical examination: Psych: Agitated mood. Angry affect. Assessment/Plan: Visual hallucinations, Psych to see patient for evaluation. Monitor mental and neurological status. Discussed plan of care with patient, nursing staff and other providers. There was no physician's order written for the psychiatry evaluation.On 9/19/25 at 9:49 AM, V19, LPN, documented a change of condition: altered mental status for R3.On 9/19/25 at 10:03 AM, V9, SSD/Social Service Director's, progress note states: patient with appeared to be a controlled substance in the room. It was a small baggy of crack cocaine with a small crack pie (pipe). Items removed from the patient's room and given to social worker. Resident educated on policy regarding contraband and risk of controlled substances. Patient receptive of education and took full accountability. Patient visits will be restricted for 30 days and visits will be supervised in a common area for 30 days.V9, SSD/Social Service Director, provided R3's Identified Offender Behavior Contract signed on 9/5/25 and 9/19/25. The contract states: Remain clean and sober, that is to refrain from any alcohol consumption and/or illicit drug use for the duration of my stay here. On 9/19/25 at 11:46 AM, V13, LPN/Licensed Practical Nurse's, progress note states: Writer informed by staff that controlled substance was found in resident room. Per MD (medical doctor) send resident to hospital for drug evaluation. Resident cleaned and sat at nurse's station for close monitoring. Ambulance arrived around 11:15 AM to pick up resident.Per nursing note, R3 returned to the facility on 9/19/25 at 8:34 PM. Frequent monitoring ongoing by staff. R3's 9/19/25 hospital records states: [AGE] year old male arrives by ambulance from nursing home- staff states he was using cocaine at the facility- patient admits to a one time use approximately 2 weeks ago. ED (emergency room) Course: Urine drug screen was positive for cocaine. Nursing home staff notified of the results and will accept him back to the facility. No documentation of frequent monitoring and supervision was provided for review by administration upon request.On 9/25/25 at 10:35 AM, V9, SSD's, progress note states: Resident was observed with illegal contraband in his possession. Resident educated on policy regarding contraband. Resident verbalized understanding. Resident verbalized consent for a room search.On 9/25/25 at 12:20 PM, V9, SSD's, progress note states: Nursing did in house drug test which concluded to be positive for controlled substance. Resident passes and