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	01/15/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure five residents (R5, R16, R58, R74, and R76), out of a sample of 54 residents reviewed for resident rights, were treated with dignity and respect.Findings include: Record review of facility mealtimes indicates the 300/400 dining room mealtime is 12:15 PM. 1.On 1/12/2025 at 12:45 PM, R71 was observed sitting in the 300/400 dining room watching other residents at R71's table eat. R71 was not served any lunch. All other residents in the dining room were served lunch and approximately 25% of the residents had finished eating. R71 affirmed R71 was hungry and didn't know why R71 was not served a lunch tray. V41 (Activity Aide) confirmed R71 did not receive a lunch tray, that all other residents were served/eating, and approximately 25% of the residents had already finished eating. V41 was unsure why R71 did not get lunch served to them, stating, I don't know what happened, I don't think a tray came down for (R71). Someone is looking into it and we're getting (R71) a tray. V41 affirmed R71 not getting a tray and having to watch other residents eat is a dignity concern and all residents should be served together. On 1/12/2026 at 12:50 PM, V7 (Dietary Manager) affirmed V7 was aware R71 did not get a lunch tray and the dietary staff were preparing a tray for R71. V7 stated, I don't think a meal ticket printed out for (R71). Everyone should be served lunch at the same time. V7 affirmed staff begin passing trays for lunch at 12:00 PM. 2.On 1/16/26 at 12:31 PM, R58 was observed, in the dining room, seated at a table with 4 (R5, R16, R74, and R76) other residents during lunch. Throughout the meal, R58 exhibited continuous drooling, which accumulated on the tabletop and on R58's clothing. The accumulation of R58's puddle of thick sputum on the table was approximately a 1/2 foot long and a foot wide. The drooling was clearly visible and persisted for an extended period of time. R58 appeared unaware or unable to manage the drooling independently and required staff support to maintain comfort and personal dignity. R5, R16, R74, and R76 at the table were visibly exposed to the situation, as the drooling remained on the shared dining surface during the meal. On 1/14/26 at 4:40 PM, V2 (Director of Nursing/DON) said, The situation (drooling during lunch) that was described to me was not acceptable. It's disgusting. The area was not cleaned immediately, and an odor could have been present. It's not fair to the other residents (residents sitting at the table during lunch). This should have been addressed promptly. Record review of facility provided pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, . Your facility must treat you with dignity and respect (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and must care for you in a manner that promotes your quality of life. Your facility must provide equal access to quality care regardless of diagnosis. Your facility must be safe, clean, comfortable, and homelike. You may participate in developing a person-centered care plan which states all the services your facility will provide to you and everything you are expected to do. This plan must include your personal and cultural choices. Your facility must make reasonable arrangements to meet your needs and choices. You should receive the services and/or items included in the plan of care.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to ensure resident call lights were within reach, failed to ensure resident equipment was clean, failed to ensure equipment (in use) was in good condition, failed to ensure sheets covered the mattress while in use, failed to ensure soiled bed linens were changed, failed to ensure requested condiments were provided, and failed to ensure staff provided assistance when resident socks were wet and needed to be changed for six of 54 residents (R2, R13, R27, R32, R88, R94) in the sample. Findings include: 1.On 1/12/26 at 10:37AM, R13's wheelchair (including wheel spokes) was notably soiled with white debris and the arm rests were severely cracked (almost all the vinyl was missing). On 1/12/26 at 10:40 AM, V23 (Central Supply) was asked about the appearance of R13's wheelchair. V23 (Central Supply) stated, It's a little old. On 1/12/26 at 10:47 AM, V13 (Wound Care Coordinator) was asked if R13's wheelchair appeared clean. V13 (Wound Care Coordinator) responded, The wheels? No. V13 was asked about the appearance of R13's wheelchair arm rests. V13 replied, The vinyl or fake leather is peeling off. 2.On 1/12/26 at 11:02 AM, R2's fitted sheet was soiled with a dried spill and corn flakes. V20 (Maintenance) was asked about the appearance of R2's bed linens. V20 (Maintenance) stated, The CNA (Certified Nursing Assistant) hasn't come and change it yet; it's probably some waste food. 3.On 1/12/26 at 11:27 AM, R32 was lying in bed (on the mattress) and the fitted sheet was at the foot of the bed. R32's modified call light was dangling from a rack and out of reach. R32 was unable to reach the call light when asked. On 1/12/26 at 11:36 AM, V14 (Licensed Practical Nurse/LPN) was asked about the location of R32's bed sheet. V14 (Licensed Practical Nurse) entered the room and stated, Well, he moves a lot, so it doesn't stay on his bed. I don't know what they have to rectify that, but it continually comes off the bed. V14 left R32's room without addressing concerns with R32's sheet and/or providing the call light. 4.On 1/12/26 at 12:11 PM, R2 received two (2) hamburgers, however, condiments were not received. R2 requested ketchup and mayonnaise at this time. V21 (Health Information Manager) provided R2 with only one (1) ketchup packet. 5.R27's face sheet documents diagnoses that include but are not limited to morbid obesity, diabetes, and COPD (chronic obstructive pulmonary disease). R27's BIMS (Brief Interview for Mental Status) score, dated 12/31/25, is 13, which indicates R27 is cognitively intact. R27's care plan, dated 12/20/25, documents, ADL (Activities of Daily Living): (R27) requires assist with daily care needs, with interventions that document, in part, Assist with resident (R27) with ADLs; Call light within reach. R27's care plan, dated 12/20/25, documents, Bed mobility: has a self-care deficit in bed mobility r/t (related to) Decreased ability to position or reposition self in bed/ Turn from side to side/ Use side rails to move in bed/ Move from lying to sitting or sitting to lying position). (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/12/26 at 10:30 AM, R27's call light was observed wrapped around R27's beside table, not within reach. R27 said, I don't know what the nurse did. I had it (call light) a certain way, but the nurse moved it and now I can't reach it. Of course I need help. On 1/12/26 at 10:55 AM, V28 (Licensed Practical Nurse/LPN) said, Oh, weird, the call light is like attached to the room light. No, she can't reach the call light; let me figure out what's going on here. 6.R88's face sheet documents diagnose that include but are not limited to dementia, cognitive impairment, and chronic kidney disease. R88's BIMS (brief interview mental status) score, dated 10/30/25, is 6 which indicates R6's cognition is severely impaired. R88's care plan, dated 7/3/25, documents, (R88) is at high risk for falls, with interventions that document, in part, Be sure the resident's (R88) call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. On 1/12/26 at 10:45 AM, R88's call light was observed behind R88's bed not within reach. On 1/12/26 at 10:47 AM, while in R88's room with V31 (Housekeeper), V31 said, I don't know why his call light is behind the bed. I just clean the rooms. 7.R94's face sheet documents diagnoses that include but are not limited to Alzheimer's, pain in right hip, and repeated falls. R94's BIMS (brief interview mental status) score, dated 10/30/25, is 3, which indicates R94's cognition is severely impaired. R94's care plan, dated 10/20/24, documents, The resident has an ADL (activities of daily living) deficit, with interventions that document R94 needs substantial assistance with bed mobility, dressing, personal hygiene, toilet use, transfer, and requires set up assistance with eating. On 1/12/26 at 12:16 PM, R94 was observed in the dining room with R94's right foot laying in puddle of water on the floor. R94 said, Can you get me some new socks. My feet are cold and wet. Someone said they are going to get new ones but never came back. On 1/12/2026 at 12:19 PM, V30 (Certified Nursing Assistant/CNA) said, That's water, not urine. (R94) sometimes drops the water when she's drinking. Yeah, that's a lot of water. No, not sure how long the water has been there. I'll take her to her room and change her socks. On 1/14/26 at 4:40 PM, V2 (Director of Nursing/DON) said call lights are expected to be within residents' reach at all times and answered timely. Review of facility policy titled, Call Light Response, dated 5/01/25, documents, 3. Ensure the call light is always within the resident's reach. 4. When the patient or resident is in bed or confined to a bed or chair, provide the call light within easy reach of the patient or resident. Record review of facility policy titled, Activities of Daily Living, dated 5/01/25, documents, A program of activities of daily living is provided to prevent disability and return or maintain residents at their maximal level of functioning based on their diagnosis. 2. A program of assistance and instructions in ADL skills is care planned and implemented. Grooming: c. Resident's facial hair should (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	be shaved if necessary and appropriate per personal preference. Feeding: Adaptive equipment, assistance and instruction are given as required. Record review of facility provided pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, . Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must provide equal access to quality care regardless of diagnosis. Your facility must be safe, clean, comfortable, and homelike. You may participate in developing a person-centered care plan which states all the services your facility will provide to you and everything you are expected to do. This plan must include your personal and cultural choices. Your facility must make reasonable arrangements to meet your needs and choices. You should receive the services and/or items included in the plan of care. The undated CNA job description states assist residents with dressing and ensure that dependent residents are dressed in clean clothing. Keep wheelchairs, and other resident equipment clean. Make beds and change bed linens when soiled.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based upon observation, interview, and record review, the facility failed to ensure esident curtains were hung properly, failed to ensure dining room tables/resident rooms are cleaned timely for four (R11, R56, R69, R88) residents, failed to ensure the 700 unit shower room was clean, failed to discard soiled toilet paper, failed to replace the shower head, failed to repair broken floor tiles in the shower, and failed to ensure soiled linen was placed in the laundry for 23 residents residing on the 700 unit in a total sample of 54 reviewed for homelike environment. Findings include: The 1/12/26 census includes 23 residents residing on the 700 unit. 1.On 1/12/26 at 10:52 AM, R11's curtain was noted to be dangling from the track with 23 hooks not attached. R11 stated, The curtains are falling off. I told 'em (sic) about a week ago to fix the curtains. One of the staff pulled it and the hooks came off. 2.On 1/12/26 at 11:20 AM, the 2nd 700 unit shower was inspected with V21 (Health Information Manager). The beige double sinks were notably soiled with a white substance. The countertop had a spilled orange substance that appeared somewhat dry, and food debris was present. V21 was asked what was on the countertop. V21 stated, It looks like soap and food. V21 was asked what was in the sinks. V21 responded, White residue. A large pile of soiled toilet paper with a brown smeared substance was observed on the floor next to the toilet. V21 was asked what was on the toiled toilet paper. V21 replied, The tissue in the corner? It looks like poop. V21 was asked if staff are supposed to monitor residents while in the shower room. V21 stated, They (staff) should, yes ma am. The ceramic tiles around the shower drain were notably broken in multiple pieces, some of which were missing, creating a safety hazard. V21 was asked about concerns with the shower tile. V21 responded, There's little broken pieces at the drain. V21 was asked why the shower head was missing in one of the showers. V21 replied, I don't know, its broken. A wet, soiled washcloth was observed dangling from the shower chair. V21 was asked about the washcloth on the shower chair. V21 stated, It looks used. A razor was also observed on the tub. V21 was asked if razors are allowed to be used by residents unsupervised. V21 responded, No. 3.On 1/12/26 at 12:10 PM, a large brown spill was observed on the table where R56 and R69 were seated (some of which appeared dried), however, there was no food and/or drinks on the table. V10 (Housekeeping Manager) attempted to clean the table, however, V10 had to scrub it to remove the substance because it was partially adhered to the table. A light stain (where the substance was spilled) was also noted on the table. V10 stated, It don't wanna come out (sic) while trying to remove the stain. V10 was asked what was on R56 & R69's table. V10 stated, It looked like coffee. 4.On 1/12/26 at 12:37 PM, a brown smeared substance was observed on the wall, the floor, and dresser in R11's room. V19 (Certified Nursing Assistant) inspected the substance and stated, It looks like poop or food or something on the wall, the floor and this dresser. 5.R88 was unable to be interviewed due to altered mental status. R88's face sheet documents diagnose that include but are not limited to dementia and cognitive impairment. R88's BIMS (Brief Interview for Mental Status) score, dated 10/30/25, is 6, which indicates (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R88's cognition is severely impaired. On 1/12/26 at 10:45 AM, human feces were observed on the floor in R88's room, next to R88's bed. On 1/12/26 at 10:47 AM, V31 (Housekeeper) said, I haven't gotten to this room (R88's) yet. I don't know what that is. Maybe it's food or something. I don't know if it's poop. I'll clean it up though. Record review of facility job description titled, Housekeeping Aide, undated, documents, Provides a clean and sanitary environment for staff and residents using proper policies and procedures. 1. Wet mops resident rooms and bathrooms daily. The safe and homelike environment policy (reviewed 1/14/25) states in accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment. This includes ensuring that the resident can receive care and services safely. Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment. Report any unresolved environmental concerns to the administrator. Record review of facility provided pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, . Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must provide equal access to quality care regardless of diagnosis. Your facility must be safe, clean, comfortable, and homelike. You may participate in developing a person-centered care plan which states all the services your facility will provide to you and everything you are expected to do. This plan must include your personal and cultural choices. Your facility must make reasonable arrangements to meet your needs and choices. You should receive the services and/or items included in the plan of care.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observation, interview, and record review, the facility failed to ensure that ADL (Activities of Daily Living) care was provided to 10 of 54 dependent residents (R1, R2, R3, R13, R27, R29, R54, R78, R79, R121) in the sample reviewed for ADL care.Findings include: 1.R1's 8/15/24 care plan states resident has an ADL self-care performance deficit related to hemiplegia/hemiparesis. R1's 12/13/25 functional assessment affirms resident is dependent on staff for dressing. R1's 12/13/25 BIMS (Brief Interview Mental Status) determined a score of 7 (severe impairment). On 1/12/26 at 10:17 AM, several large white clumps of food were observed on R1's chest. R1 affirmed he was served Grits for breakfast. R1 also affirmed he was unable to move the right upper and lower extremities. On 1/12/26 at 10:22 AM, V14 (LPN/Licensed Practical Nurse) stated, I see he dropped some food on his shirt. R1 replied, I ate some grits today and it fell out the bowl. V14 made no effort to remove the food off R1's chest and/or change his shirt. 2.R13's 7/30/24 care plan states resident has an ADL self-care performance deficit related to intervertebral disc disorders with myelopathy, lumbar region. R13's 11/19/25 functional assessment affirms resident requires partial/moderate assistance with dressing and substantial/maximal assistance with personal hygiene. R13's 11/19/25 BIMS determined a score of 13 (cognition intact). On 1/12/26 at 10:37 AM, R13 was wearing a black shirt which was notably covered in white debris. R13's beard and mustache were long, R13 was asked if R13 prefers to be shaved. R13 stated, I gotta (sic) get that done but the barber only comes once a month and affirmed he requires assistance with shaving. R13's nails were long and broken. R13 was asked who cuts R13's nails. R13 responded, Nobody. On 1/12/26 at 10:47 AM, V13 (Wound Care Coordinator) stated, There's white specs that I see all over his shirt. 3.R2's 7/30/24 care plan states resident has an ADL self-care performance deficit related to lack of coordination. R2's 12/3/25 functional assessment affirms resident requires partial/moderate assistance for personal hygiene. R2's 12/3/25 BIMS determined a score of 14 (cognition intact) On 1/12/26 at 11:07AM, R2's fingernails were long and broken. R2 was asked about R2's fingernails. R2 stated, I pick at 'em. (sic) R2 was asked if R2 can cut his own nails. R2 responded, No, I just pick at 'em. (sic) (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4.R79's 7/31/24 care plan states resident has an ADL self-care deficit related to stroke. R79's 12/8/25 functional assessment affirms resident is dependent on staff for toileting. R79's 12/8/25 BIMS determined a score of 15 (cognition intact). On 1/12/26 at 11:38 AM, the front of R79's incontinence brief appeared to be saturated and the lines on the front of the brief were dark blue (indicating the diaper was wet). V14 (Licensed Practical Nurse/LPN) untaped the brief, lowered it, and stated, It looks like he's wet. I'm going to have to send somebody in here to change you then taped the diaper back on the resident and left the room. V14 was asked why R79's diaper was saturated. V14 responded, The CNA (Certified Nursing Assistant) is probably in another person's room doing patient care. 5.R1's 12/13/25 functional assessment affirms resident requires partial/moderate assistance with eating. On 1/12/26 at 12:44 PM, V16 (CNA) served R1's lunch (in the room) and stated, Your lunch is here. I'm going to put it in front of you so he you can eat then exited the room. V16 was asked if R1 can feed himself. V16 responded, Yes, he feeds himself. R1 attempted to eat carrots with a spoon without assistance and accidentally pushed them off the plate onto the tray. R1 had difficulty feeding himself due to flaccid right upper extremity and inability to use both hands. On 1/14/26 at 12:49 PM V35 (Registered Dietician) was asked if R1 can feed himself. V35 (Registered Dietician) responded, It depends on the day. I do believe he should be a 1:1 feed though. 6.R29 is [AGE] years old, admitted [DATE], with a past medical history including chronic obstructive pulmonary disease, muscle wasting, unspecified lack of coordination, obesity class 3, type 2 diabetes, syncope, and collapse. Minimum Data Set (MS) assessment, dated 12/16/2025, indicated R29 is cognitively intact and requires partial/moderate to substantial t/maximal assistance for most Activities of daily Living (ADL) needs. Section H (bowel and bladder) of the same assessment documented R20 is frequently incontinent of bowel and bladder. Care plan initiated 12/11/2025 stated resident requires assist with daily care needs. Interventions include assist with ADL needs, keep clean and dry after each incontinent episode, etc. On 01/12/2026 11:10 AM, R29 was in a room with family members, alert and oriented, and stated she is concerned with sitting in her urine for an extended period, especially on night shift. R29 said the night staff usually comes in around 11PM, will change residents once, and then again around 4 AM. R29 said she knows how to use her call light, but no one answers the light. She does not know her shower days, and the Certified Nurse Assistants (CNAs) give millions of excuses when a resident requests a shower. R29 added she has not received a shower since last week. R29 is scheduled for showers on Tuesdays and Friday, the last documented shower for R29 is on January 6, 2026. 7.R78 is [AGE] years old, admitted on [DATE], with a medical history including other acute osteomyelitis, left ankle and foot, muscle wasting and atrophy, sepsis unspecified organism, type 2 diabetes, mixed hyperlipidemia, and peripheral vascular disease. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MDS (Minimum Data Set) assessment, dated 12/18/2025, section C (cognitive) indicated R78 is cognately intact, Section GG (functional) indicated R78 requires partial/moderate assistance with ADL needs, section H bowel and bladder) documented R78 is occasionally/frequently incontinent of bowel and bladder. Care plan, revised 12/25/2025, stated R78 requires assist with daily care needs. Interventions include assist resident with ADLs, goal: staff will anticipate and meet all of resident's needs daily. Interventions: assist resident with ADLs, keep clean and dry after each incontinent episode, etc. On 01/12/2026 10:55AM, R78 was observed in his room, awake and alert, and stated he is doing okay. R78 added he has an issue with getting his showers. The facility told him he is scheduled on Thursday and Fridays, but staff does not give one to him. R78 is scheduled for showers on Tuesdays and Fridays. R78 received two showers, on 12/26/2025 and 1/6/2026, since admission, as documented in shower sheets provided by facility. 8.R54 is [AGE] years old, admitted on [DATE]. R54's face sheet listed the following medical history: metabolic encephalopathy, other lack of coordination, cognitive communication deficit, aphasia following cerebrovascular disease, systemic lupus, type 2 diabetes, and repeated falls. R54 is assessed as being cognitively intact, requires substantial/maximal assistance for toileting, dressing and personal hygiene, and dependent on staff for shower/bathing, toileting and transfers. R54 is also assessed as being frequently incontinent if bowel and bladder. Incontinence care plan, revised 12/25/2025, stated R54 requires staff assistance with toileting and toileting hygiene. Interventions include monitor toileting hygiene and assist as needed, help with toileting hygiene at routine intervals, keep skin clean, dry and moisturized, etc. On 01/12/2026 3:10PM, R54 was observed in her room, up in wheelchair. R54 stated she has been waiting to be changed since after lunch. R54 stated staff kept on telling her to wait, they are looking for someone to help them, and they never came back. R54 said she is wet and had a bowel movement. R54 stated they do this to her all the time; she sits in her waste for an extended period and that is not right. 01/12/2026 3:15PM, V33 (Registered Nurse/RN) stated the morning CNA for the resident left already, but she will find someone to help the resident. 9.R121 is [AGE] years old, admitted on [DATE], with a medical history including: chronic obstructive pulmonary disease, with acute exacerbation, morbid (severe) obesity due to excess calories, hyperlipidemia, major depressive disorder, and blindness one eye. MDS assessment, dated 1/6/2026, indicated R121 is cognitively intact and dependent on staff for most ADL care needs. Care plan, revised 10/23/2024, stated R121 has functional urinary and bowel incontinence related to impaired mobility, interventions include check for incontinent episode regularly throughout the shifts, provide incontinent care after each incontinent episode, report any signs of skin breakdown, etc. On 01/13/2026 8:36 AM, R121 was in her room awake and alert, and stated she is doing okay. R121 was observed eating breakfast and said breakfast is okay today. R121 said she sometimes sits in her urine and feces for hours before being changed. On night shift they have one CNA (Certified Nursing Assistant) for both the 100 and 200 units. They are supposed to have 2 but will pull one to another (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unit when they are short. R121 said she is very upset about that; no one should sit in their waste waiting to be changed for hours. On 1/13/2025 at 2:45PM, V2 (DON) said showers are scheduled two times a week are supposed to be provided as scheduled. Staff are supposed to document if a shower or bed bath is provided on the shower sheet. 10.On 1/12/26 at 10:30 AM, R27 was observed with visible facial hair along R27's chin area. The hair appeared as a small cluster of dark, coarse strands extending a few millimeters in length, noticeable at conversational distance. R27 said, You think I haven't asked to get rid of these hairs on my face? I even told the nurse the other day just get me the pink bucket thingy and a razor, and I'll try to do it (shave). As you can see, I still haven't gotten these hairs removed. On 1/13/26 at 8:35 AM, V3 (Assistant director of Nursing/ADON) and V33 (Registered Nurse/RN), V3 said, (R27) we'll get you shaved and cleaned up after you receive your meds if you'd like. R27 replied, I've been asking for a razor for my face, even asked for that pink thing to do it myself. 11.R3's face sheet documents an admission date of 9/08/2025, and diagnoses that include but are not limited to dysphagia, chronic atrial fibrillation, constipation, hypertension, and chronic pulmonary artery disease. R3's BIMS (Brief Interview for Mental Status) score, dated 12/15/2025, is 3, which indicates R3's cognition is severely impaired. R3 unable to be interviewed due to altered mental status. R3's care plan, dated 9/08/25, documents, Nutritional Status at risk for weight loss due to mech (mechanical) altered diet, dysphagia, decreased po (by mouth) intakes, skin alterations, dementia, current sig (significant) weight loss. R3's care plan does not identify that R3's weight loss was unavoidable. R3's care plan, dated 9/12/25, documents, (R3) has been observed experiencing the following depressive symptoms (Little interest in once pleasurable things, Tired, fluctuation in sleep patterns, little to no appetite). R3's active physician order, order date 12/04/25; end date indefinite, documents, 1:1 assistance while eating or drinking with meals. On 1/12/2026 at 12:23 PM, R3 was observed receiving her lunch tray. From 12:23 PM to 12:47 PM, there was no staff member observed providing one-to-one feeding assistance to R3. Staff were observed assisting other residents in the dining room; however, no staff member was observed assisting R3 to provide continuous feeding assistance as ordered. R3 did not receive prompts, physical assistance, or supervision consistent with one-to-one feeding during the observation period. No staff member returned to provide the ordered assistance prior to the end of the observation. On 1/12/2026 at 12:47 PM, V30 (Certified Nursing Assistant/CNA) said, (R3) does not require 1:1 feeding. No, she eats fine, just like the rest of us. On 1/13/26 at 12:26 PM, V35 (Registered Dietician) said R3 is a 1:1 feed. On 1/14/26 at 4:40 PM, V2 (Director of Nursing/DON) said staff are expected to follow physician (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	orders and care plans. V2 affirmed if it's not charted, it's not done. R3 is a 1:1 feed and that is provided by the wound care tech. V2 sated V2 was unaware R3 did not have a 1:1 during lunch on Monday (1/12/26) and V2 stated V2 would find out what happened. The undated CNA job description states assist residents with dressing and ensure that dependent residents are dressed in clean clothing. Keep resident's finger and toenails clean and trimmed. Activities of Daily Living policy, revised 5/1/2025, stated in general: a program of activities of daily living is provided to prevent disability and return or maintain residents at their level of functioning based on their diagnosis. Guideline: 1 The ability of each resident to meet the demands of daily living is determined by a licensed nurse.2. A program of assistance and instructions in ADL skills is care planned and implemented. Under procedure (f): Showers and baths are scheduled, and assistance is provided when required. Incontinence care policy, revised 05/2025, states incontinence care is provided to keep residents as dry, comfortable and odor free as possible. It also helps in preventing skin breakdown Record review of facility policy titled, Baseline Care Plan, dated 1/2023, documents, To provide the staff with guidance on completion of comprehensive person-centered care baseline care planning. The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care. The baseline care plan will include at a minimum the following necessary information to properly care for a resident: Supervision needs, activities of daily living needs, dietary orders. Record review of facility policy titled, Activities of Daily Living, dated 5/01/25, documents, A program of activities of daily living is provided to prevent disability and return or maintain residents at their maximal level of functioning based on their diagnosis. Grooming: c. Resident's facial hair should be shaved if necessary and appropriate per personal preference. Record review of facility provided pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, . Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must provide equal access to quality care regardless of diagnosis. Your facility must be safe, clean, comfortable, and homelike. You may participate in developing a person-centered care plan which states all the services your facility will provide to you and everything you are expected to do. This plan must include your personal and cultural choices. Your facility must make reasonable arrangements to meet your needs and choices. You should receive the services and/or items included in the plan of care.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement fall prevention interventions and failed to provide supervision to one of 54 residents (R140); failed to ensure the 300 unit emergency exit door (egress) was able to be opened; and failed to ensure the 300 unit emergency exit door alarmed when opened affecting twelve 300 unit residents. Findings include: 1.R140 was [AGE] years old admitted to the facility on [DATE], with diagnoses which include but not limited to dementia, metabolic encephalopathy, adult failure to thrive, muscle wasting/atrophy, lack of coordination, and repeated falls. R140 was transferred to the hospital on 9/23/25 post fall(s) and did not return to the facility. R140's (8/28/25) admission evaluation includes a fall risk score of 21 (high risk). R140's (9/8/25) BIMS (Brief Interview Mental Status) determined a score of 7 (severe impairment). R140's (9/8/25) functional assessment affirms resident required substantial/maximal assistance with chair/bed to chair transfer. Walking was not attempted. R140's (8/29/25) care plan includes but not limited to; resident is at high risk for falls, interventions: move resident to room with optimal visual access from the nurse's station. Staff to assist as needed. R140's (9/23/25) progress notes document, 5:24 PM, the resident was observed on the floor on the right side of the bed in a prone position. The resident was assisted off the floor and assessment done. Resident has a raised area to the left forehead. Safety precaution is maintained. (Ambulance) notified of resident condition eta (estimated time of arrival) 45 minutes. 5:54pm (30 minutes later), The resident was in bed and rolled out. The resident is unable to recall what happened related to cognitive state. LOC (Level of Consciousness) remains the same alert x1 with confusion. Raised area noted to the left side of the forehead, no bleeding or bruising noted. The resident was assisted off the floor by staff and placed in the bed. Family notified. MD (Medical Doctor) made aware received new order to send to ER (Emergency Room) for evaluation. 6:31pm, (Ambulance) arrived resident transferred to hospital. (9/24/25) The resident was admitted to hospital, diagnoses: systemic Inflammatory Response Syndrome, dehydration, elevated liver enzymes, fall and contusion (bruise) of the head. R140's (9/23/25) 5:30pm, incident report affirms staff entered the room and the resident was observed laying on the floor. Resident unable to give description [Witnesses are excluded]. Predisposing factors: confused, impaired memory, and antipsychotic use. R140's (9/23/25) EMS (Emergency Medical Service) Patient Care Report states ambulance was dispatched to the scene for a [AGE] year-old who suffered from an (unwitnessed) fall. Patient does take 5 milligrams of Eliquis (blood thinner). Upon arrival, patient presented with a 3-inch hematoma on the left forehead. R140's (9/23/25) History & Physical states, patient is a [AGE] year-old female who presented to the ED (Emergency Department) status/post fall at nursing home. Patient is unable to provide any (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	history, moans when touched but non-verbal. Head CT (Computed Tomography) with 1. moderate left frontal scalp hematoma without underlying calvarial fracture. 2. Asymmetric trace thickening of the left cerebellar tentorial leaflet, which is favored to represent [NAME] calcification, less likely trace subdural hemorrhage. No associated mass effect. On 1/13/26 at 10:58 AM, V2 (Director of Nursing) stated, Her (R140) score was 21 (8/28/25) so she's high risk for falls. On 1/13/26 at 9:25 AM, V32 (Nurse Consultant) stated, She (R140) didn't have any major injury; she had a scalp hematoma. On 1/14/26 at 12:59 PM, surveyor attempted to reach V39 (LPN/Licensed Practical Nurse) assigned to R140 (9/23/25) via phone to no avail. On 1/14/26 at 2:02 PM, surveyor attempted to reach V39 (again) via phone to no avail. On 1/14/26 at 4:30 PM, V2 (Director of Nursing) stated, There's no open area, the CT was negative for any fracture. On 1/15/26 at 10:01 AM, surveyor attempted to reach V39 (LPN) a third time via phone to no avail. On 1/15/26 at 11:08 AM, V45 (CNA/Certified Nursing Assistant/ R140's 9/23/25 assigned CNA) stated, I don't work there, I don't want to work there and hung the phone up. On 1/15/26 at 11:20 AM, surveyor attempted to reach V46 (CNA) assigned to R140's unit on 9/23/25 via phone; the line was busy. At 11:23 AM, surveyor attempted to reach V46 again, however, the line was still busy. On 1/15/26 at 11:30 AM, surveyor attempted to reach V47 (CNA) assigned to R140's unit on 9/23/25 via phone, however, the phone rang several times then disconnected. R140's (10/5/25) Certificate of Death states Cause of Death: Cerebrovascular Disease with Dementia. Manner of Death: Natural, The fall prevention policy (reviewed 7/2025) states while preventing all falls is not possible, 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. Residents at risk for falls will have fall risk identified on the interim plan of care with interventions implemented to minimize fall risk. A fall risk evaluation is completed by the Nurse. A score of 10 or greater indicates the resident is at high risk for falls. Care plan to be updated with a new intervention based on root cause analysis after each fall occurrence. 2.Facility census for 1/12/2025 documents in part that 12 residents reside on the 300 unit. On 1/12/2025 at 10:58 AM, observed the emergency door alarm light at the top of the door not illuminated. A notice was posted on the door that indicates the door will alarm and the locking mechanism will be disengaged after holding the push bar of the door for 15 seconds. V8 (Maintenance Director) observed the alarm light and stated, We have been having issues with this door and the alarm (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sensitivity. V8 held the push bar of the door and no alarm sounded, and after 20 seconds, the door was still locked. V8 leaned V8's shoulder and applied full body weight to the door in attempt to open the door and the bottom of the door opened approximately 12 inches, but the door remained locked and unable to be opened. On V8's final attempt of getting the door open, an alarm sounded but the door did not unlock. V8 affirmed when the push bar is applied, the alarm should sound, and the lock should disengage after 15 seconds. V8 explained the 300 unit is a dementia care unit and the purpose of the alarm is to prevent elopement. V8 added the purpose of the door disengaging is that so staff and residents can escape if there was an emergency. Facility preventative maintenance policy (5/2025) documents in V8 is responsible for checking the operations of fire doors.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, failed to implement care plan interventions, failed to follow physician orders, failed to notify the physician of abnormal urine, failed to document abnormal urine, failed to obtain orders for urinalysis/culture, failed to ensure urinary catheter bags remain below the bladder level to prevent backflow and potential UTI (Urinary Tract Infection), and failed to ensure a nephrostomy tube drainage bag was placed below the kidney level to prevent backflow of urine into the kidney and the potential for kidney infection. These failures affected three residents (R1, R4, R13) in the sample of 54 residents. Findings include: 1.R1's diagnoses include (6/7/25) UTI. R1's 12/7/25 Physician Order Sheets state change urinary bag as needed when clinically appropriate every 8 hours as needed. R1's 6/5/25 care plan states resident requires use of an indwelling catheter related to diagnosis of neuromuscular dysfunction of bladder. Intervention: keep drainage bag lower than level of bladder. Monitor for signs/symptoms of UTI. Notify medical doctor of abnormal findings. Change catheter as needed. On 1/12/26 at 10:17 AM, R1's indwelling urinary catheter tubing was notably cloudy with chunks of purulent substance floating in the urine and heavy sediment. R1's urinary catheter bag was undated. Surveyor inquired when R1's catheter and/or bag were last changed; R1 was unsure. R1's (January 2026) MAR (Medication Administration Record) states change urinary bag as needed when clinically appropriate every 8 hours as needed however nothing was documented. On 1/12/26 at 10:22 AM, R1 was lying in bed. V14 (Licensed Practical Nurse/LPN) was asked about the appearance of R1's indwelling urinary catheter and contents in the bag. V14 (Licensed Practical Nurse) responded, I see his discoloration, sediment. V14 was asked if R1's catheter bag was dated. V14 removed the bag from the bed rail, raised it above R1's bladder and replied, It's not. V14 was asked if V14 notified the doctor regarding R1's abnormal urine. V14 stated, I haven't, no, I didn't call the doctor about that. V14 was asked where catheter/bag changes were documented. V14 responded, Probably under his profile in the progress notes. V14 reviewed R1's EMAR (Electronic Medical Records) stated he was unsure when the catheter bag was placed/changed. On 1/14/26 at 1:16 PM, V2 Director of Nursing/DON, was asked if orders were obtained for urinalysis and urine culture (on 1/12/26) for R1's abnormal urine. V2 (DON) stated, That I'm not sure about, I would have to check. On 1/14/26 at 3:20 PM, V40, Medical Director, was asked what cloudy urine with sediment and chunks of purulent drainage floating in a catheter is indicative of. V40 (Medical Director) stated, It can be many things. We would want to rule out UTI. If they see a change in the color or the sediment, nursing staff should bring it up with the DON (Director of Nursing) or the provider for sure. V40 was asked what should be ordered if urine appears abnormal. V40 replied, Urinalysis but also a culture. On 1/14/26 at 4:43 PM V36, Nurse Practitioner, was asked if V36 was notified of R1's abnormal urine. V36 stated, (R1's) a hospice patient. I was asked to look at a urinary catheter, but it was (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	already changed before I looked at it. The DON called and said it was sediment or something in the urinary catheter. V36 was asled if a urinalysis or urine culture was ordered for R1 on 1/12/26. V36 responded, No ma am, this is a hospice patient. I refer them back to hospice. I reminded the nurse to call the hospice. R1's progress note on 1/12/26 at 12:14 PM states, called hospice, got order to change (urinary catheter). 2.R13's diagnoses include obstructive and reflux uropathy. R13's 7/25/25 physician orders state change urinary bag as needed when clinically appropriate. R13's (11/19/25) BIMS (Brief Interview Mental Status) determined a score of 13 (cognition intact). On 1/12/26 at 10:37 AM, R13 was asked how frequent staff change R13's indwelling urinary catheter bag. R13 stated, It's supposed to be once a week. R13 was asked when R13's catheter bag is changed. R13 responded, When they decide to change it. R13's (January 2026) MAR includes change urinary bag as needed when clinically appropriate, however, nothing is documented. On 1/12/26 at 10:45 AM, V13, Wound Care Coordinator, was asked about the appearance if R1's indwelling urinary catheter. V13 responded, It's white residue. V13 was asked what white residue is indicative of. V13 didn't respond. V13 then asked V14 (LPN) How often the order is to be changed? 3.R4's care plan, dated 12/19/25, states R4 has a nephrostomy bag; intervention states to observe for signs of skin irritation, keep skin clean, dry, and moisturized. On 1/12/26 at 10:40 AM, R4 was observed awake in bed with the nephrostomy drainage bag on top of her abdomen, showing only about one tablespoon of urine in the drainage bag. At 10:55 AM, R4's nephrostomy drainage bag was still in the same position. At this time, V26 (CNA/Certified nurse assistant) she did not know what kind of urine bag it was, but that it should be hanging down on the side of the bed to allow proper drainage. Immediately, V26 brought the drainage bag below R4, about 200 ml(milliliters) of the urine came out into the drainage bag. V27 (LPN/Licensed Practical Nurse) stated she was not sure what kind of catheter it was and she would go back and check. V27 came back and stated R4 has nephrostomy catheter that is connected directly to the kidney. V27 stated the drainage bag should be placed below the resident to allow gravity drainage and she would educate the CNA to be sure the drainage bag is placed below the level of the kidneys. On 1/12/26 at 12:55 PM, V2(Director of Nursing) stated V27 should have been given shift report that R4 has a nephrostomy tube. V2 added backflow of urine could cause kidney infection, and staff would be re-educated about this. Facility's Policy titled Nephrostomy Management, dated 1/2025, states: Residents with Nephrostomy will receive care consistent with professional standards of practice.#4b: Keep the drainage bag below the level of the kidney at all times. The indwelling catheter care policy (revised 5/2025) states daily and PRN (as needed) catheter care will be done to promote comfort and cleanliness. Catheter bag to be emptied at the end of every (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shift, and PRN. Record output and catheter care in POC (Plan of Care)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interview and record review, the facility failed to have sufficient staff to provide nursing and related services as determined by assessments, individual plan of care, number of residents, acuity and diagnoses of the facility's resident population in accordance with the facility assessment. This failure has the potential to affect all 131 residents currently at the facility.The 1/12/26 facility census includes 73 (2nd floor) residents. 1.R1 resides on the 2nd floor. On 1/12/26 at 10:17 AM, R1 was lying atop of a LALM (Low Air Loss Mattress), however, the setting was on static (firm) mode (the setting should be on alternate mode - while lying in bed). Several large white clumps of food were observed on R1's chest. R1 affirmed he was served Grits for breakfast. R1 also affirmed he was unable to move the right upper extremity. R1's indwelling urinary catheter tubing was notably cloudy with chunks of purulent substance floating in the urine and heavy sediment. On 1/12/26 at 10:22 AM, V14, Licensed Practical Nurse, was asked if R1 has any wounds. V14 (LPN/Licensed Practical Nurse) stated, He does have wounds. R1 responded, On my legs. V14 was asked about R1's LALM settings. V14 stated, Wound Care handles the settings. I guess they base it on his (R1's) weight. V14 was asked what static mode indicates on R1's LALM. V14 responded, I'm assuming it alternates the pressure for him. V14 was asked if V14 knows when the LALM static mode should be used. V14 stated, No, I don't and failed to change R1's LALM settings to alternate mode. V14 was asked about the white clumps of food observed on R1's chest. V14 responded, I see he dropped some food on his shirt. R1 replied, I ate some grits today and it fell out the bowl. V14 made no effort to remove the food off R1's chest and/or change his shirt. V14 was asked about the appearance of R1's indwelling urinary catheter and contents in the bag. V14 responded, I see his discoloration, sediment. V14 was asked if R1's catheter bag was dated. V14 removed the bag from the bed rail, raised it above R1's bladder and replied, It's not. V14 was asked if V14 notified the doctor regarding R1's abnormal urine. V14 stated, I haven't, no I didn't call the doctor about that. V14 was asked where catheter/bag changes are documented. V14 responded, Probably under his profile in the progress notes. V14 was asked when R1's urinary catheter was placed and/or bag changed. V14 reviewed R1's EMAR (Electronic Medical Records) to no avail and affirmed he was unsure. 2.R13 resides on the 2nd floor. On 1/12/26 at 10:37 AM, R13 was wearing a black shirt which was notably covered in white debris. R13's beard and mustache were long. R13 was asked if R13 prefers to be shaved. R13 stated, I gotta (sic) get that done but the barber only comes once a month and affirmed he requires assistance with shaving. R13's nails were long and broken. R13 was asked who cuts R13's nails. R13 responded, Nobody. R13 was asked how frequent staff change R13's indwelling urinary catheter bag. R13 stated, It's supposed to be once a week. R13 was asked when R13's catheter bag was changed. R13 responded, When they decide to change it. R13's (January 2026) Medication Administration Record includes change urinary bag as needed when clinically appropriate, however, nothing is documented. At 10:47 AM, V13, Wound Care Coordinator, was asked about the appearance of R13's shirt. V13 (Wound Care Coordinator) stated, There's white specs that I see all over his shirt. 3.R11 resides on the 2nd floor. (continued on next page)

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/12/26 at 10:52 AM, R11's curtain was noted to be dangling from the track with 23 hooks not attached. R11 was asked about the curtain. R11 stated, The curtains are falling off. I old 'em (sic) about a week ago to fix the curtains. One of the staff pulled it and the hooks came off. 4.On 1/12/26 at 11:20 AM, the 2nd floor 700 unit shower was inspected with V21 (Health Information Manager). The beige double sinks were notably soiled with a white substance. The countertop had a spilled orange substance that appeared somewhat dry and food debris was present. V21 was asked what was on the countertop. V21 stated, It looks like soap and food. V21 was asked what was in the sinks. V21 responded, White residue. A large pile of soiled toilet paper with a brown smeared substance was observed on the floor next to the toilet. V21 was asked what was on the toiled toilet paper. V21 replied, The tissue in the corner? It looks like poop. V21 was asked if staff are supposed to monitor residents while in the shower room. V21 stated, They should, yes ma am. The ceramic tiles around the shower drain were notably broken in multiple pieces, some of which were missing, creating a safety hazard. V21 was asked about concerns with the shower tile. V21 responded, There's little broken pieces at the drain. V21 was asked why the shower head was missing in one of the showers. V21 replied, I don't know, its broken. A wet, soiled washcloth was observed dangling from the shower chair. V21 was asked about the washcloth on the shower chair. V21 stated, It looks used. A razor was also observed on the tub. V21 was asked if razors are allowed to be used by residents unsupervised. V21 responded, No. 5.R32 resides on the 2nd floor. On 1/12/26 at 11:27 AM, R32 was lying in bed (on the mattress) and the fitted sheet was at the foot of the bed. R32's modified call light was dangling from a rack and out of reach. R32 reached for the call light to no avail and was unable to reach it. On 1/12/26 at 11:36 AM, V14, Licensed Practical Nurse/LPN, was asked about the location of R32's bed sheet. V14 (LPN) stated Well, he moves a lot, so it doesn't stay on his bed. I don't know what they have to rectify that, but it continually comes off the bed. V14 subsequently left R32's room without addressing concerns with R32's sheet and/or providing the call light. 6.R79 resides on the 2nd floor. On 1/12/26 at 11:38 AM, the front of R79's incontinence brief appeared to be saturated and the lines on the front of the brief were dark blue. V14 was asked about R79's brief. V14 (LPN) untaped the brief, lowered it and stated, It looks like he's wet. I'm going to have to send somebody in here to change you, then taped the brief back on the resident and left the room. V14 was asked why R79's diaper was saturated. V14 responded The CNA (Certified Nursing Assistant) is probably in another person's room doing patient care. R79's g (gastrostomy) tube feeding (Jevity 1.5 Cal) was infusing at 50 ml (milliliters) per hour. R79's Jevity bottle was hung at 12:30am (per container), however, roughly 1300ml were still in the 1500ml container, therefore, only 200ml was infused over the past 11 hours. V14 was asked about R79's Jevity orders. V14 (Licensed Practical Nurse) stated, I'm going to have to look at that. V14 was asked if V14 hung R79's Jevity. V14 responded, No, I didn't. V14 inspected R79's Jevity container and stated, I guess they hung it at midnight, the time they have on the bottle. V14 was asked how many milliliters were left in R79's Jevity container. V14 responded, 1275 to 1250. V14 was asked how roughly 1300mls remained in R79's Jevity container if the infusion rate is set at 50ml/hour, and the container was hung 11 hours ago. V14 replied, That's a good question. 7.R56 and R69 reside on the 2nd floor. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/12/26 at 12:10 PM, a large brown spill was observed on the table where R56 and R69 were seated (some of which appeared dried), however, there was no food and/or drinks on the table. V10 (Housekeeping Manager) attempted to clean the table, however, had to scrub it to remove the substance because it was partially adhered to the table. A light stain (where the substance was spilled) was also noted on the table. V10 stated, It don't wanna come out (sic) while trying to remove the stain.V10 was asked what was on R56 & R69's table. V10 stated, It looked like coffee. On 1/12/26 at 12:24 PM, V17, Licensed Practical Nurse/LPN was asked about the current 2nd floor staffing. V17 (LPN) stated, We have two Nurses; one on 5/6 (500/600 units) and a Nurse on 7/8 (700/800 units) and one 4-hour Nurse, and affirmed there are 5 CNAS (Certified Nursing Assistants) on dayshift due to 800 unit currently closed. V17 was asked how many (2nd floor) residents require mechanical lift transfer. V17 responded 5 or 6. V17 was asked how many 2nd floor residents require assistance. V17 replied, Most of the residents require assist. Surveyor reviewed the 1/12/26 (500/600) dayshift daily assignment sheet, V17 affirmed one of five CNAs were crossed off, therefore, only 4 were assigned to those units. 8.On 1/12/26 at 12:37 PM, a brown smeared substance was observed on the wall, the floor, and dresser in R11's room. V19, CNA, was asked about the substance on the wall, floor, and dresser in R11's room. V19 (CNA/Certified Nursing Assistant) inspected the substance and stated, It look like poop or food or something on the wall, the floor and this dresser. 9.On 1/12/26 at 12:44 PM, V16 (CNA) served R1's lunch in the room and stated, Your lunch is here. I'm going to put it in front of you so he you can eat, then exited the room. V16 was asked if R1 can feed himself. V16 responded, Yes, he feeds himself. R1 attempted to eat carrots with a spoon without assistance and accidentally pushed them off the plate onto the tray. R1 had difficulty feeding himself due to flaccid right upper extremity and inability to use both hands. 10.On 01/12/2026 11:10AM, R29 was in her room with family members, alert and oriented, and stated she is concerned with sitting on her urine for an extended period, especially on night shift. R29 said the night staff usually comes in around 11PM, will change residents once, and then again around 4am. R29 does not think that the facility has enough staff. 11.On 1/12/2026 at 10:19AM, V33 (Registered Nurse/RN) was observed in the 100/200 unit of the facility passing medication. V33 said she is the only nurse scheduled for the 2 units, with 2 Certified nursing assistants (CNAs). Facility rosters indicate there are 25 residents on both floors. Review of daily schedule for 1/12/2026 provided by the facility showed 2 nurses on that floor, one full time and one part time that will start at 11:00AM. On 1/12/2026 at 3:10PM, surveyor asked V33 (RN) if any other nurse came in at 11:00AM on her unit and she said no, she was the only nurse on day shift for both units. V33 added she has been assigned to 25 to 28 residents in the past and that is standard for the facility. On 1/12/2026 at 3:46PM, V2 (DON) said it was only one nurse on the 100 and 200 unit; the other nurse on the schedule was a mistake because she took over from another staff in the 500 unit that went home at 11:00AM. V2 added having one nurse for 25 residents is their normal scheduling, they only have 2 nurses in the 100/200 unit when it is full and that has not happened since she started here in July of 2025. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	12.On 01/12/2026 10:55AM, R78 was observed in his room, awake and alert, and stated he is doing okay. R78 added he has an issue with getting his showers; they told him that he is scheduled on Thursday and Fridays, but staff does not give it to him. R78 thinks the facility is short of staff. 13.On 01/12/2026 3:10PM, R54 was observed in her room up in wheelchair. R54 stated she has been waiting to be changed since after lunch. Staff kept on telling her to wait, they are looking for someone to help them, and they never came back. R54 said she is wet and had a bowel movement, they do this to her all the time. She sits in her waste for an extended period and that is not right. R54 has left sided weakness and is supposed to be on restorative care but stated no one is providing her with any restorative care and her left hand is painful. 14.On 01/13/2026 8:36 AM, R121 was in her room awake and alert and stated she is doing okay. R121 was observed eating breakfast and said that breakfast is okay today. R121 said she sometimes she sits in her urine and feces for hours before being changed. On night shift they have one C.N.A for both the 100 and 200 units; they are supposed to have 2 but will pull one to another unit when they are short During this survey, concerns were identified with accommodation of needs, activities of daily living care, housekeeping, restorative care, safety, medication storage/labeling, and significant weight loss due to prescribed enteral feedings not received and/or 1:1 feeding assistance not provided. On 1/14/2026 at 1:17PM, V2 (DON) said the facility only has 2 restorative aides. They used to have 3 but one left. The DON is also the restorative nurse; the facility does not have any restorative nurse currently. V2 is not sure if anyone has provided restorative care for R54. On 01/13/2026 11:15 AM, V12 (Staffing Coordinator) said she has been doing staffing for the facility since February 2025 and generally depends on the census to determine staffing. If the census is 145, she will schedule 5 nurses on day shift and evening shift and 4 nurses for 3rd shift. Certified Nurses Assistants will be 12 on morning and afternoon shifts and 9 on night shift. The staffing breakdown according to units is as follows: 100/200 units- 1 Nurse and 2 CNAs for all three shifts (Census 1/12/2026 26 residents) 300/400 units- 1 Nurse and 2 CNAs for all three shifts. (Census 1/12/2026- 32 residents). 500/600 units -2 Nurses and 3 CNAs for morning and afternoon shifts and 1 Nurse and 3 CNAs for night shift. Census 1/12/2026 (50 residents) 700 unit- 1 Nurse and 2 CNAs all three shifts, one CNA slits between the 700 unit and 600 unit. (Census on 1/12/2026 23 residents) The 800 unit is closed currently. V12 said, Census of 145 is considered a full house. I have never scheduled more than 1 nurse on the 100/200 unit. I was not aware that one CNA is pulled from that unit on night shift. If there is a call off, they should pull from the 500/600 unit with 3 CNAs. V12 stated V12 has never received any concerns regarding staffing, the facility is currently hiring, does not use any agency. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility assessment, dated 12/2025, documented under staffing plan the total number of licensed nurses providing direct care, including wound care nurses and nursing supervisors is 20 to 25 per day. Nurse aides including restorative aides is 35 to 35 per day, other nursing personnel (MDS nurses, Wound Care Coordinator, Restorative Nurse, infection prevention Nurse) will be 4-6 per day. In addition to nursing staff, other staff needed for behavioral healthcare and services (list other positions/roles), Social workers, Activity Director/aides, Director of Customer Experience, Psychologist (s), Psychiatrist, LCSW. The facility assessments also listed the following staffing ratios: For Nurses, post-acute unit is 1:20 all sifts. Long term care units 1:25 all shifts. For CNAs, the ratio for both post-acute and long term is 1:12 all shifts. Facility schedule provided during the survey and staffing coordinator's interview indicates te facility is not scheduling enough staff to provide care to residents according to facility assessment. The staffing policy (reviewed 5/2025) states staffing is based on the IDPH (Illinois Department of Public Health) formula for determining numbers and levels of staff. Staffing is then increased based on the needs of the resident population. Staffing is supplemented as needed by outside entities

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure that posted nursing staffing information was complete and accurate. This failure has the potential to affect all 131 residents residing at the facility.Findings include:On 1/12/2026, upon entrance to the facility at 9:00AM, surveyor observed a daily staffing posting on a board behind the reception desk. Upon review of the posting, surveyor observed only the column for the number of staff was completed. The second column, actual hours worked and the 3rd column, total hours were left vacant. The same postings were observed behind the reception desk on 1/13/2026 and 1/14/2026.On 1/14/2026 around 2:30PM, surveyor asked the receptionist who is responsible for the staff posting, and she said the staffing coordinator is responsible. She brings it down every day, and she just puts it in a drawer when a new one is brought down the following day.On 1/14/2026 at 4:18PM, V12 (Staffing Coordinator) said she is in charge of the nursing staff posing and has been doing it since she started working at the facility in February 2025. Surveyor presented the two columns on the posting that were not completed and V12 said that she overlooked those, moving forward, she will correct that.

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Put firmly secured handrails on each side of hallways. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure corridors have firmly secured handrails. This failure has the potential to affect all 32 residents that reside on the 300 and 400 units. Findings include: Facility census documents 12 residents reside on the 300 unit, and 20 residents reside on the 400 unit. On 1/12/2026 at 10:56 AM, observed the handrails loose (unsecured) and able to shift approximately 2 inches up or down outside room [ROOM NUMBER], 310, 311, and 312. The handrail outside room [ROOM NUMBER] was able to shift approximately 4 inches up or down, and all screws were visible loose coming out of the brackets. When light pulling pressure was applied to the handrail, the handrail began to disconnect from the wall. V8 (Maintenance Director) observed the handrails and confirmed the observations. V8 affirmed handrails should be tightly secured to the walls. V8 stated residents use the handrails for balance, safety, and to propel themselves down the hallway when in a wheelchair. On 1/14/2026 at 3:17 PM, observed the handrails loose (unsecured) outside room [ROOM NUMBER] across from the nurse's station, the rails by room [ROOM NUMBER]/412, 409/410, 407/408, between room [ROOM NUMBER] and the janitor closet. The handrails were also not secured between 405/406 and a hole approximately 5 inches tall by 3 inches wide was observed where the bracket to the handrail is secured to the wall. Additionally, screws could be seen approximately 1 inch from the wall that attached the bracket to the wall. V1 (Administrator) and V8 observed the handrails and confirmed the observations. V1 asked if V8 checked all the handrails after V8 was aware the handrails in the 300 were loose, and V8 replied V8 only checked and fixed the 300 unit handrails. Record review of the facility preventative maintenance policy (5/2025) does not document inspections of the facility's handrails are to be completed as part of the preventative maintenance in the facility.