

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000477		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/19/2025	
NAME OF PROVIDER OR SUPPLIER RYZE AT HOMEWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 19000 SOUTH HALSTED , HOMEWOOD, Illinois, 60430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S0000	Initial Comments		S0000				
	Complaint Investigations 2598732/2614005 and 2598479/2610514						
S9999	Final Observations		S9999				
	Statement of Licensure Violations:						
	300.610 a)						
	300.1210 b)						
	300.1210 c)						
	300.3210 t)						
	Section 300.610 Resident Care Policies						
	a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.						
	Section 300.1210 General Requirements for Nursing and Personal Care						
	b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.						
	c) Each direct care-giving staff shall review and be						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 knowledgeable about his or her residents' respective resident care plan. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements are not met as evidenced by: 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 62-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 71-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			S9999			

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S9999	Continued from page 2 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 states 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".			S9999			

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S9999	Continued from page 3 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 was sent out to the hospital for further evaluation due to blunt head trauma. Record review of R4's Social service assessment are as follows: R4's "Behavior Assessment", dated on 8/25/2025, states R4 observed being verbally and physically aggressive towards another resident. Responding to internal stimuli R4 remains unable to be redirected. R4's "Behavior Assessment", dated 8/25/2025, states in his Behavioral symptoms include physical aggression towards self/others, and verbal aggression. R4's Response to Interventions states that R4's behavior increased/escalated, and that R4 did not respond to interventions successfully. R4's "Potential for Abuse and Neglect Assessment", dated 8/26/2025, stated R4's Mental/Emotional Challenges said R4 has persistent anger, fear and/or anxiety, poor judgment skills, and psychotic symptoms such as hallucinations or delusions. R4's Behavioral		S9999				

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S9999	Continued from page 4 Challenges include history of aggressive, combative or abusive physical behaviors, and history of verbally threatening or verbally obnoxious behaviors. 2. R1 is a 62 year old with the following diagnosis: type 2 diabetes, alcohol dependence, cocaine use, and intervertebral disc displacement in the lumbar region. R5 is a 63 year old with the following diagnosis: cerebral infarction and type 2 diabetes. R1 no longer resides in the facility. On 9/16/25 at 12:01PM, R5 stated R5's previous roommate (R1) slapped R5 in the head about one week ago. R5 reported R5 got up from bed, walked into the bathroom, and closed the door. R5 stated R1 began yelling and opened the door on R5 then slapped R5 on top of the head. R5 reported R5 then yelled at R1 to stop touching R5 and staff came into separate them. R5 stated R1 began yelling that R1 was going to use the bathroom and that is when R1 opened the door and slapped R5. R5 reported R1 was lying in R1's bed and said nothing to R5 while R5 walked to the bathroom. R5 said, "I had no idea he needed to use the bathroom until he was screaming at me after I closed the door." R5 stated R1 has been verbally aggressive with R5 before but never physical until 9/11/25. R5 reported R1 would tell R5 that R5 was messy and "make a big deal out of little stuff" such as a paper towel left on the floor. R5 stated R1 would call R5 a slob. On 9/17/25 at 11:25AM, V2 (Social Service Director) stated a nurse texted V2 that R1 hit R5. V2 reported R1 was going to be petitioned out to the hospital for a psych evaluation but R1 left the facility against medical advice instead. V2 stated R1 is normally verbally aggressive and manipulative. V2 reported staff will redirect R1's behavior when possible but R1 cannot be redirected every time. V2 stated the police came to the facility and gave R1 a citation. V2 reported R5 told V2 that R5 went to the bathroom which is connected to R1's room and when R5 closed the door to R1's room, R1 opened the bathroom door and slapped R5 on top of the head with an open head. V2 stated this incident would be considered physical abuse because R1 made physical contact with R5 that was unwanted by R5. On 9/17/25 at 1:17PM, V4 (LPN) stated V4 overheard R1 and R5 arguing so V4 went to see what happened. V4 reported R1 told V4 that R1 was going to the bathroom and left out to get a hand towel when R5 came in to use the bathroom when R1 wasn't done. V4 stated the CNA then reported that R5 told the CNA that R1 hit R5 on	S9999					

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S9999	Continued from page 5 the head. V4 reported R1 has been verbally aggressive in the past so staff know how to redirect R1's behavior. V4 stated the police showed up to talk with both residents. V4 reported this incident would be considered physical assault. On 9/17/25 at 1:55PM, V5 (Director of Nursing/DON) stated the nurse reported R1 and R5 got into an altercation. V5 reported V5 explained to R1 that R1 would have to go to the hospital for a psych evaluation but R1 refused. V5 stated R1 told staff that R1 was using the bathroom and left to grab something out of R1's room when R5 entered the bathroom and shut R1's door. V5 reported R1 then told R5 that R1 wasn't finished in the bathroom and R5 grabbed something off the sink that belonged to R1 so R1 grabbed R5's arm. V5 stated R1 admitted to "tussling" with R5. V5 defined "tussling" as pushing back and forth. V5 reported R1 told V5 that the tussling continued until R5 called out for help. V5 stated that V5 wasn't exactly sure R5's side of the story but R5 did corroborate that R1 got physical with R5. V5 reported the police came to the facility to issue R1 a citation. V5 stated this incident would be considered physical abuse. On 9/18/25 at 12:00PM, V1 (Administrator) stated R5 reported R1 hit R5 on the top of the head and R1 reported R1 physically moved R5 out of the doorway. V1 reported the police were called at the request of R5 and they issued R1 a citation for slapping R5 without any legal justification. A Nursing note, dated 9/11/25, documents R1 presented with physical aggressive behavior towards a peer. R1 was not receptive to staff redirection. Social services attempted to petition R1 to the hospital for a psych evaluation. R1 refused to go to the hospital and wanted to sign out against medical advice (AMA) instead. A Nursing note, dated 9/11/25 documents R5 informed the nurse that R1 struck R5 on the head. The nurse assessed R5 and R5 was stable with no changes. The physician and emergency contact were notified. A Social Service note, dated 9/11/25, documents Social Services met with R5 following the altercation. R5 discussed with events leading up to the altercation with R1. Police were made aware. The Initial Incident Report, dated 9/11/25, documents R5 reported R1 slapped R5 on top of the head without justification. Residents were separated. Body assessment was completed with no injuries noted. R1 was put on 1:1 monitoring until R1 discharged. Police were		S9999				

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S9999	Continued from page 6 notified. An investigation was initiated. The Ordinance Violation from the police, dated 9/11/25, documents R1 slapped R5 on top of the head without any legal justification. R1 must appear for an administrative hearing. The Potential for Abuse and Neglect Form, dated 9/11/25, documents R1 has poor judgement skills, a history of physical abuse, history of being verbally threatening, and history of being aggressive. R1 also has a history of substance abuse and alcoholism. R1 was involved in a physical altercation with a peer. R5's Potential for Abuse and Neglect Assessment, dated 9/11/25, documents R5 is at risk for abuse due to using a wheelchair. R1's Care Plan, dated 8/18/25, documents R1 is at risk for abuse. R1 was involved in a physical altercation with a peer on 9/11/25. This care plan also documents R1 presents with behavioral symptoms by becoming verbally aggressive with staff. R1 is not receptive to redirection. The Care Plan dated 9/9/25 documents R1 presents with manipulative behaviors and make false allegations regarding staff. The Care Plan dated 9/11/25 documents R1 present with physically aggressive behavior. R1 was involved in a physical altercation with a peer on this day. R5's Care Plan, dated 9/11/25, documents R5 is at risk for abuse and neglect. R5 was involved in a physical altercation with a peer on this day. R1's Minimum Data Set (MDS), dated 8/18/25, documents a Brief Interview for Mental Status Score (BIMS) as a 15 (no cognitive impairment). Section E documents R1 has exhibited verbally aggressive behavior within one to three days from this assessment. The Minimum Data Set for R5 dated 8/22/25 documents a Brief Interview for Mental Status score as 15 (no cognitive impairment). A policy titled, "Abuse Policy and Prevention Program," dated 10/2022 documents, "This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents...Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of	S9999					

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S9999	Continued from page 7 injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident...Physical abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment.” (B)		S9999				