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 12/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RYZE AT HOMEWOOD	**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 Complaint Investigations: 2599723/2635266 2599659/2636744 2599866/2639224	S0000		01/16/2026
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610a) 300.1010h) 300.1210b) 300.1210c) 300.1220b)7)8) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety	S9999		01/16/2026

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

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 12/31/2025

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S9999	Continued from page 1 or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. (B) 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 knowledgeable about his or her residents' respective resident care plan. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 7) Coordinating the care and services provided to residents in the nursing facility. 8) Supervising and overseeing in-service education, embracing orientation, skill training, and on-going education for all personnel and covering all aspects of resident care and programming. The educational program shall include training and practice in activities and restorative/rehabilitative nursing techniques through out-of-facility or in-facility training programs. This person may conduct these programs personally or see that they are carried out. These REQUIREMENTS are not met as evidenced by: 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.	S9999		

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S9999	Continued from page 2 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	S9999		

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S9999	Continued from page 3 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	S9999		

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S9999	Continued from page 4 (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 12/08/2025 at 1:47pm, V7 (Registered Nurse/RN) said, "I was still on orientation at the time. I was with (V16, Licensed Practical Nurse/LPN). I started on September 2nd (9/02/2025) and came off orientation in the middle of October (October 2025). I am a new nurse. Everything was fine that day. I was passing medications as usual and taking vital signs. (R1) was diabetic, so I obtained a blood sugar reading. Everything was normal, and I administered his insulin. I then continued up the hall. I completed all of my medications independently; I was passing meds on my own, and my preceptor was not observing me at that moment. Later, we (V7 and V16) were both in the same room. I don't really know the last time I saw (R1), maybe 1 hour, not sure. (V16) attempted to obtain the resident's blood sugar, but (R1) was unresponsive. I immediately went to call a Code. (V16) began CPR (cardiopulmonary resuscitation), and we all rotated in providing compressions. The crash cart was brought to the room. (V16) did not obtain a blood sugar because the resident was unresponsive." On 12/08/2025 3:02pm, V17 (Medical Doctor) said, "Yes, I'm familiar with (R1). I do remember treating (R1) at the facility." When asked if the nurse notified V17 of R1's fall at the time of the fall, V17 replied, "Yes." When V17 was notified that V14 (Registered Nurse/RN) stated V14 did not speak with V12, but left V12 a message, V12 replied, "There is no way I did not speak with someone about an unwitnessed fall. We (V17 and V2/DON/Director of Nursing) discussed the situation at length, the Director of Nursing and I. If a resident is on blood thinners and experiences an unwitnessed fall, we (facility staff) typically send them out for further evaluation and perform neurological checks. But this was not the case. Head trauma is especially concerning when a resident is on anticoagulants. In situations involving head trauma, I rely on the nurse's assessment. With a witnessed fall, we can determine whether head trauma occurred. With an unwitnessed fall, we assume the possibility of head impact. We only send	S9999		

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S9999	Continued from page 5 residents out for evaluation after a fall with head impact if they are taking blood thinners." On 12/08/25 at 3:14pm, V16 (Licensed Practical Nurse/LPN), said, "I was orienting another (V7/Registered nurse/RN) nurse, and she mentioned that something did not look right about (R1). Oh, I can't remember when I last saw him (R1). I noticed that he was not responding. I checked his vital signs and, seeing that he was a full code, I initiated a Code Blue, because I could not feel a pulse. We applied the AED and continued CPR until the paramedics arrived. I also notified the family and the physician. The paramedics came and continued CPR and ultimately confirmed that he had passed away. The family arrived later. I had taken his vital signs at the start of the shift. The other nurse had administered his medications at the beginning of the shift. He was the first resident whose vitals I completed. I performed all necessary interventions when he was found unresponsive. I do not remember what his blood sugar was. I was not aware (R1) fell the day before." On 12/08/25 at 1:52pm, V1 (Administrator) was asked for the policy and/or protocol for an unwitnessed head injury, including not sending a resident out with a potential head injury because the resident is not receiving anticoagulant therapy. V1 replied, "Okay, let me ask Corporate." On 12/09/25 at 10:11am, V1 (Administrator) said, "The policy ("Fall Prevention and Management", dated 7/2025, is the only one we have. This policy does not address unwitnessed falls and/or facility protocol on anticoagulation therapy with possible head trauma." On 12/10/25025 at 1:44pm, V2 (Director of Nursing/DON) said, "That ("Fall Prevention and Management", dated 7/2025) is the only fall policy we have. We do not have a fall policy or protocol that specifies unwitnessed falls. Our facility follows the state required guidelines. There can be difference for witnessed and unwitnessed falls. For a witnessed fall, you can actually see what happened. An unwitnessed fall you have to rely on what the patient tells you." V2 affirmed not all patients can give a description on how the fall occurred. V2 affirmed an unwitnessed fall may change the clinical management of the resident. V2 said, "I did speak to the nurse the day (R1) fell. I spoke with the doctor (V17/medical doctor), I think, the next day. I speak with (V12) all the time." Record review of facility policy titled, "Fall Prevention and Management", dated 7/2025, does not	S9999		

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S9999	Continued from page 6 address the required actions for managing unwitnessed falls, including guidance related to residents who are or are not receiving anticoagulant therapy. Review of R1's EMR (electronic medical record) shows a physician note from V17 (medical doctor) for service dates of 9/30/25 and 10/03/25. There was no observed note regarding the notification of the physician and/or the assessment of the physician regarding R1's fall that occurred on 10/04/2025. Facility provided in-service titled, "Fall Risk Assessment", undated, listing staff names that were in-serviced on Fall Risk Assessments. The "Fall Risk Assessment" in-service did not include documentation of the date and time it was conducted, nor did it specify the educational content that was provided. 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." Record review of CMS's RAI (Resident Assessment Instrument) Chapter 4: CAA Process and Care Planning, dated October 2024, documents, in part, "A "fall" refers to unintentionally coming to rest on the ground, floor, or other lower level but not as a result of an external force (e.g., being pushed by another resident). A fall without injury is still a fall. Falls are a leading cause of morbidity and mortality among the elderly, including nursing home residents." Record review of facility policy titled, "Change in Resident Condition," dated 7/2025, documents, "It is the policy of the facility, except in a medical emergency, to alert the resident, resident's physician and resident's responsible party of a change in condition. 1. Nursing will notify the resident's physician or nurse practitioner when: a. The resident is involved in an accident or incident. 2. Once the physician has been notified and a plan developed, the nursing or social service staff will alert the resident and family of the issue and any physician orders. 3. The communication with the resident and their responsible party if they are not their own as well as the physician will be documented in the resident's	S9999		

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S9999	Continued from page 7 medical record or other appropriate documents." Record review of facility policy titled, "Fall Prevention and Management," dated 7/2025, documents, "This facility is committed to maximizing each resident's physical, mental, and psychosocial well-being. While preventing falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventative strategies, and facilitate as safe an environment as possible. All residents shall be reviewed, and the residents existing plan of care shall be evaluated and modified as needed. A fill risk assessment is completed on admission, readmission, and quarterly, significant change and after each fall. Residents at risk for falls will have fall risk identified on the interim plan of care with interventions implemented to minimize fall risk." Review of 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… You must not be abused, neglected, or exploited by anyone - financially, physically, verbally, mentally, or sexually… 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." (A) 2 of 2 300.610a 300.690a) 300.690b) 300.690c) 300.1210b) 300.1210c)	S9999		

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S9999	Continued from page 8 300.1220 b)3) 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 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. Section 300.1210 General Requirements for Nursing and Personal Care	S9999		

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S9999	Continued from page 9 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 knowledgeable about his or her residents' respective resident care plan. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. These REQUIREMENTS are not met as evidenced by: Based on interview, and record review, the facility failed to notify Illinois Department of Public Health and complete a thorough investigate to determine how one resident (R3) was able to acquire and abuse illicit drugs on multiple occasions while residing in the facility, failed to further prevent illicit drugs from entering the facility, and failed to take corrective action as a result of investigation for one (R3) of three resident reviewed for incident and accidents. 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. Findings include: R3 is 70 years of age. Current diagnoses include but are not limited to Chronic Obstructive Pulmonary Disease, Asthma, and Chronic Kidney Disease. R3 has a	S9999		

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S9999	Continued from page 10 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 9/2/25. 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 10/3/25 for chest pain. While hospitalized on 10/3/25, 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	S9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RYZE AT HOMEWOOD	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
S9999	Continued from page 11 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: 70 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 visits still restricted until 10/19.2025. Nursing staff continue to monitor. IDT (interdisciplinary team) made aware.	S9999		

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S9999	Continued from page 12 On 9/25/25 at 12:55 PM, R3 was sent to the hospital by V10, RN, for altered mental status with expected controlled substance use. V10 documented POA (Power of Attorney), NP, DON, and Administrator made aware. On 9/25/25, R3's hospital records state: Chief complaint: Patient presents with Altered Mental Status, Hallucinations. Nursing facility staff called EMS (emergency medical services) due to patient having hallucinations and more agitated than usual. Nursing facility staff found a crack pipe in patient's briefs. Per ER (emergency room) physician note, patient admitted to using crack cocaine. Laboratory urine drug screen was positive for cocaine. Nursing progress note on 9/30/25 states: R3 admitted from hospital. Patient presented to ED from facility due to AMS (altered mental status) and hallucinations related to substance abuse. On 10/1/25 at 11:50 AM, V37, NP/Nurse Practitioner's, initial evaluation states: 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 10/3/25 at 2:47 PM, V25, RN/Registered Nurse, progress note states: change in condition, chest pain. On 10/3/25 at 11:19 PM, V31, NP/Nurse Practitioner, was called to R3's room by V3, ADON, to evaluate him for chest pain. R3 was sent to the hospital for further evaluation. The 10/3/2025 hospital records document the urine toxicology screen was positive for cocaine, fentanyl, and opiates. The hospitalist history and physical by V39, MD/Medical Doctor, states: When patient got to the floor, the nurse found cocaine and pipes in his pockets. R3's care plan states: Substance Abuse: R3 has a history of substance abuse/chemical dependency. R3 had crack cocaine in his possession on 9/19/2025. 2nd incident with resident having an illegal controlled substance of crack cocaine in his possession on 9/25/2025. Date initiated 9/19/2025 by V9, Social Service Director.	S9999		

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S9999	Continued from page 13 Interventions: Meet with IDT (interdisciplinary team) to discuss extent of illness. Physician may consider a referral to psychiatrist and/or write an order restricting "pass privileges". Date initiated 9/19/2025. V9 SSD. Work with the resident to establish a verbal and/or written behavioral contract specifying what is and what is not allowed. Make sure the resident is aware of rules prohibiting use of alcohol, illicit substances, and intoxication. Date initiated 9/19/2025. V9 SSD. There are no additional interventions documented after R3 was hospitalized on 9/19/2025 or 9/25/25 regarding being evaluated by psychiatry, having a substance abuse assessment, a referral for substance abuse treatment or group therapy. R3's physician orders document the following: drug screen 9/13/2025. All outside passes are revoked for 30 days from September 19, 2025 to October 19, 2025. Resident cannot go out on pass with anyone 9/19/2025. All visits are to be in the 2nd floor dining room only for 30 days from September 19, 2025 to October 19, 2025. 9/19/2025. Naloxone HCL Spray 4mg (milligrams) 1 spray in nostril every 5 minutes as needed for opioid overdose. R3's behavior monitoring and intervention task by staff CNAs was reviewed from September - October 2025. R3 returned to the facility from the hospital on 9/19/25 at 8:34 PM. There is no documentation of frequent monitoring from 3pm-11pm shift and 11pm-7am shift. There is no documentation of frequent monitoring on 9/20/25 for 7am-3pm shift, 3pm-11pm shift and 11pm-7am shift. There is no documentation of frequent monitoring on 9/21/25 for 7am-3pm shift and 11pm-7am shift. From 9/22/25 - 9/25/25 there is no documentation for all shifts. From 9/26/25 - 9/29/25 R3 remained hospitalized. R3 returned to the facility on 9/30/25 at 5:02 PM.	S9999		

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S9999	Continued from page 14 There is no documentation of frequent monitoring from 3pm-11pm shift. There is no documentation of monitoring on 10/01/23-10/2/25 for all shifts. On 12/08/25 at 12:25 PM, V9, Social Service Director (SSD), was asked about R3 and the 9/19/25 and 9/25/25 incidents. V9 said, "(R3) was here last summer when I started, so I was familiar with him, and knew he had a drug history. I don't think it (drug history) was on his initial assessment when he came back this time. I believe V29 (Former Wound Care Nurse) found the drugs during care. It was a white powered substance. I saw it. (R3) went to the Activity Director and told her he used drugs. She brought him to me, and I had a conversation with him. He denied it at first. He was jittery, his mouth was moving a lot, he had disorganized conversation and was a little agitated because we were questioning him. He wouldn't tell me where he got it. He was going back and forth admitting and denying it. He'd been here a couple of weeks. He had a supervised pass because he wasn't here long enough for the independent pass. After the incident, the pass was revoked for thirty days. He had a behavior contract because he was an identified offender. His behavior was a red flag because he's alert and oriented and his conversation was off, and I knew something wasn't right. I notified (V2, DON/Director of Nursing) and they sent him out. He had supervised visits when he came back. He wasn't allowed to leave the facility with anyone. (V11, Former Administrator) handled it; we didn't call the police. I don't know why the police weren't called, I gave it (alleged drugs) to (V11). She said she'd handle it and it was out of my hands at that point." V9 said the second incident of illicit drugs being found was on 9/25/25. V9 said, "The second time (V10, RN/Registered Nurse) found it (drugs) in his room, I was called. (R3) had disorganized conversations, he was going back and forth admitting and denying he used. He was tested for drugs. I didn't do the drug test, nursing did. (V11), (V10, RN) and I went into the room, and I had a conversation with him. When I got there the drugs weren't there. (R3) was saying he didn't wanna (sic) do drugs, but he wouldn't tell me where he got it from. I checked the visitor logs myself; I saw a visitor. (R3's) pass was restricted for another 30 days. He was sent to the hospital the next day for something else, not drugs. (V11) said she'd dispose of it in the dumpster. I asked to notify the police, but (V11) didn't think it was necessary."	S9999		

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S9999	Continued from page 15 On 12/09/25 at 11:54 AM, V12, Activity Director, said, "Twice he came to me with his personal stuff. It was a small, sealed pack with a grey colored substance. I turned it over to Social Service. He didn't tell me what it was. (R3) said, 'That's my stuff, it's mine. I don't want this.' He was slurring his speech. I let nurse know to check him." On 12/09/25 at 12:26 PM, V10, RN, said, "(R3) was delightful, alert and oriented x 2-3. I was rounding and he was doing a lot of mouth moving, very agitated, hallucinating, complaining of chest pain. This wasn't usual for him, so I performed a urine drug test, and he was fine with it. The results said it was positive for cocaine and something else, but I'm not sure what it was. I told (V9, SSD) and (V11, Previous Administrator). His speech was disorganized. We couldn't understand what he was saying. I called the doctor and sent him out. (V9, SSD) and (V11) checked his room. He didn't admit to me he took anything. I didn't find anything and nothing was told to me. I can't remember reporting to the police." On 12/09/25 at 12:55 PM, V2, DON/Director of Nursing, provided the visitor log. There is one visit documented for R3 on 09/15/2025 from 11:53 AM to 12:18 PM. V2 said, "(R3) never went out but he had a visit." On 12/10/25 at 12:30 PM, V2, DON, was asked about R3 being sent to the hospital on 9/19/25, 9/25/25, & 10/3/25. V2 said, "I'm not sure if I was here for the first incident. I was there for the second one. I wasn't aware there were drugs found in his room. I saw the drug pipe on (V11's, previous administrator) desk, not sure the exact date. I didn't see the substance. We had suspicion that he used so we did a urine test, and it was positive for cocaine. We told his doctor and sent him to the emergency room. The hospital did a drug screen, and it was positive for cocaine as well. Social Service did the behavior contract on 9/19, and he went on pass restriction. He couldn't go out the facility for 30 days unless a doctor appointment, then it would be reassessed. His visits would be monitored and in a public area. Any packages delivered we'd look at the items to see if any contraband was delivered. On Friday 9/19, V13, LPN/Licensed Practical Nurse, sent him out to the hospital and he came back to the facility. My investigation was he returned from the hospital positive for cocaine and treatment of a UTI (urinary tract infection). Nurses did daily assessments; we chart by exception if something is going on. We monitor for changes in behavior. I didn't do an investigation. We did an IDT (interdisciplinary team) meeting and put those interventions in place. Social Service searched	S9999		

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S9999	Continued from page 16 his room. I didn't ask him any questions." About the 9/25/25 incident, V2 said, "Social service charted (R3) had drugs in his possession, and he was given a urine test. It was positive for cocaine. The 9/15 visit was the only one associated with his name. He was readmitted from the hospital on 9/30. I wasn't involved with any investigation." About the 10/3/25 incident, V2 said, "He (R3) didn't go out because of drugs, it was for a medical reason. I'd have to check what it was for." On 12/10/25 at 2:10 PM, V1, Administrator, was asked about investigating an incident involving a possible controlled substance in the facility. V1 said, "If something is found, it would have to be identified that it is a controlled substance. We contact the physician and 911. I would call the police, speak to them, and turn it over to them. After, we send the resident out to the hospital to get tested. The hospital will identify if the resident had taken a substance. Once cleared by the hospital on return, we monitor the resident. Our Social Service would go through the behavior contract. We check the log to see if the resident went out. For residents with substance abuse, we'd check if they are bringing things in with deliveries; check with family. If the resident is cognitive, we talk to them, family, interview staff that was mainly around the resident to find out what happened." On 12/15/25 at 8:51 AM, V2, DON, was asked about V11, Previous Administrator's, departure. V2 said, "She left the company, she resigned October 24th." On 12/15/25 at 11:19 AM, V9, SSD/Social Service Director, was asked about identifying the white substance found in R3's room on 9/19/25. V9 said, "I really didn't know what it was, I just assumed. Just based on knowing what it looks like, I just handed it over to (V11, Previous Administrator). I was told she put in in a drug buster." On 12/15/25 at 1:51 PM, V10 was asked about the 9/18/25 progress note written at 7:57 PM. V10 is on the schedule for the 7am-3pm shift. V10 said, "I work full time. I can't recall if I stayed over, but I did chart that note. On 9/18 I charted because he (R3) had increased confusion and agitation. I wanted to rule out a UTI (urinary tract infection). I don't remember what NP (nurse practitioner) I spoke to. I got an order for a U/A (urinalysis) to rule out a UTI because of his behavior. I hadn't seen any other behaviors, and it	S9999		

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S9999	Continued from page 17 concerned me." On 9/25, I saw him with the same behaviors and confusion as the first time. He was agitated with hallucinations. I told him we needed to collect a urine sample. I didn't tell him what it was for. A NP (Nurse Practitioner) gave me the order; I can't remember which one. We have urine cups for drug testing. It has a strip on it with abbreviations of the drugs it tested for. His read positive for cocaine and benzos. There was a prescription medication he was on for the benzos (benzodiazepines). I told the NP, DON, and (V11, Previous Administrator). I never saw anything in his room." Review of R3's physician orders do not document any benzodiazepine medication prescribed. On 12/15/25 at 2:26 PM, V6, Certified Nurse Assistant (CNA) said, " He (R3) didn't require much assistance from us. His room was junky. We'd offer to help, we tried to straighten it up, but he didn't want our help. He'd be in his room talking to himself, arguing with someone who wasn't there and scaring his roommate. He'd be hallucinating. I didn't see aggressive behavior, just erratic. He'd be in and out of his room. He came out for meals and his medicine. I didn't notice any other residents in his room. The next day the 11:00pm to 7:00am aide said he was found with drug paraphernalia. He was in his room telling people not to touch his stuff. On 9/25 we noticed immediately; he had the same behavior, hallucinating." On 12/15/25 at 2:54 PM, V2, DON, was asked about R3's visitor on 9/15/25. V2 reviewed the September visitor log. V2 said, "The visitor is from his insurance; that's the name written above his on the log. Other than that, he didn't have any outside visitors." On 12/16/25 at 10:33 AM, V24, CNA/Certified Nursing Assistant, was asked about R3 on 9/19/25. V24 said, "I worked the day it happened the first time. I noticed he (R3) was all over the place. He usually has sense. This morning, he had food all over the floor, stuff thrown everywhere. He hung out with (R9), they'd be in and out of his room. (R9) left; he's not there anymore. He (R3) was hallucinating, fighting the air, he said he was hallucinating. When I walked in the room, I stepped on half of the drug pipe. I picked it up with my gloves on; it was on the floor on the side of his bed. It was burned at one end. It was like 7 in the morning. I took it to (V15, Wound Nurse). He said he'd report it. The staff searched his room. They found drugs; it was white and the other piece of the pipe. Nobody talked to me after it happened. It happened twice with the same resident. The second time staff found a bunch of pens	S9999		

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S9999	Continued from page 18 burned at the end." On 12/16/25 at 10:49 AM, V13, LPN/Licensed Practical Nurse, said, "I remember what happened, but I don't remember the resident too well. (V15, Wound Nurse) told me he found something in his room. I remember he was aggressive, refusing to be searched. I don't remember what was found." On 12/16/25 at 11:43 AM, V15, Previous Wound Care Nurse/LPN, said, "I remember him (R3). I went to his room there was an aide there, can't remember who. I saw all his stuff on the floor. I saw a clear small baggy on the floor, looked like crack cocaine and a pipe with a burned end. The room was trashed, stuff all over. I put it in a bag and reported and turned it in. I don't remember who I gave it to. He was a little erratic. I was doing wound care that day. I'm not sure what happened to him after that." On 12/16/25 at 12:40 PM, V31, NP/Nurse Practitioner, said, "I was called by the ADON (Assistant Director of Nursing). I saw him (R3); he was having chest pain. Paramedics were at the bedside when I got there. He had some lip smacking. If we know they had an ER (emergency room) visit, we try to see them within 48 hours. We rely on the hospital after visit summary to see what they were seen for. If it wasn't uploaded in his records I wouldn't see it. The nurses don't give it to us. I saw him for a lab review because he had a UTI (urinary tract infection). I didn't know about cocaine use. That explains his lip smacking." On 12/16/25 at 1:09 PM, R3 said, "I had used cocaine. I spent my own money. Another resident brought it in for me and I went down and got it. The other resident got it for me because the person who sold it wouldn't give it to me because he didn't know me. I don't remember who he was. He was on the other unit I think. I made a mistake getting it. It stays in your system a long time. They found other stuff in my urine. I don't know what they cut it (cocaine) with. I had my cell phone, and I went to his room and got it. When they found it (cocaine) it was in the room. I only did a little of it. Other residents did it (cocaine). They couldn't get it themselves, so it was brought it." On 12/17/25 at 12:06 PM, V11, Former Administrator, said, "From what I remember, somebody found a crack pipe and a plastic bag with an unknown substance in his (R3's) room. (V9, SSD/Social Service Director) and I interviewed him (R3), and he wouldn't admit to it. He was sent out to the hospital. He did test positive for cocaine, I believe. He came back and his visiting was	S9999		

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S9999	Continued from page 19 changed to supervised and his pass was restricted. That's all I can recall about what we did for him. We didn't call police; no reason to. I destroyed it with (V3, ADON/Assistant Director of Nursing). I investigated with interviews from staff, residents, and him (R3). They should be at the facility. I can't recall if he had a history of substance abuse history. I just know he went to the hospital on 9/25 for altered mental status. I don't remember anyone finding anything in his room. I don't remember anything about him testing positive for cocaine when he came back from the hospital. I wasn't aware of him going to the hospital on 10/3." On 12/17/25 at 1:00 PM, V31, NP/Nurse Practitioner, was asked about providing psychiatric services to the residents. V31 said, "We write the order for a psych evaluation. We don't do any psych services here." On 12/17/25 at 1:38 PM, V1, Administrator, was asked about R3's substance abuse assessment and psychiatric evaluation. V1 said, "(V9, SSD/Social Service Director) said he didn't have a psych eval because he doesn't have a psych diagnosis." V1 provided R3's 9/3/25 social service initial comprehensive assessment with question #4 highlighted: History of substance use/abuse (alcoholism, drug abuse including prescription drug abuse/narcotic seeking) and/or compulsive behavior (uncontrolled or poorly controlled gambling, overeating, exercise, obsessions). A. Yes, is marked. This is the only documentation received. On 12/17/25 at 2:15 PM, V37, NP, was asked about her progress note for R3 on 10/1/25. V37 said, "It was my initial visit; I was introducing myself and going over his reasons for admission. I was asked to see him because the nurse said he was having behaviors and hallucinating. His nurse told me he said he had a history of this behavior from a previous UTI (urinary tract infection). I can't remember the nurse. I wrote for a psych evaluation and discussed it with the nurse and resident. My expectation is for the nurse to follow my plan and place the order for him to see psych. Nurses should coordinate with management to make sure it's carried out. The DON (Director of Nurses) is responsible for the nurses." On 12/17/25 at 2:40 PM, V3, Assistant Director of Nursing (ADON), regarding R3's incident on 9/19/25, said, "I was informed by (V9, SSD) that he (R3) had a white substance in a bag in his room. (V9) said she believed it was some type of drug. I knew that the	S9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RYZE AT HOMEWOOD	19000 SOUTH HALSTED , HOMEWOOD, Illinois, 60430

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S9999	Continued from page 20 resident should have been assessed, drug tested and seen by the medical provider and check his room. I never saw it with my two eyes. I don't recall any results from the hospital. I don't remember destroying anything with (V11, Previous Administrator). He (R3) did come back to the facility. He was on restricted/supervised visits." Regarding R3's 9/25/25 incident, V3 said, "I don't remember the 9/25/25 issue at all." Regarding R3's 10/3/25 incident, V3 said, "I remember (V25, RN) told me (R3) was having chest pain. We both did further assessments, vital signs, asked him to rate his pain and where it was, checked his respiratory. We checked his medications to see if he had any prn (as needed medications) and we let the nurse practitioner know. We notified (V31, NP). I don't recall getting information from the hospital about him." On 12/22/25 at 9:39 AM, R10 was asked about R3 being his roommate and the incidents on 9/19/25 and 9/25/25. R10 is alert and oriented x 3. R10 appears very guarded. R10 said, "I'm familiar with his name. Yes, he was in here. I don't feel comfortable having this conversation today." On 12/23/25 at 1:13 PM, V2, DON, was asked about R3's referral to psychiatry. V2 said, "Generally the NP (Nurse Practitioner) will put the order in and the nurses will confirm the order. For the psych evaluation, the nurse would add the resident to the list to be seen by psych. If the resident doesn't get seen and they're having behavioral issues it could lead to them harming themselves or someone else." On 12/23/25 at 4:29 PM, V42, Medical Director, said, "(V2, DON/Director of Nursing) updated me with his (R3) hospitalization with polysubstance abuse. The last time he went out to the hospital for chest pain, and he was positive for cocaine and fentanyl. I'm not his attending, so I wasn't told immediately when it happened. We discussed that we are not trained in addiction specialty and how do we put interventions in place. We've had policies in place for residents with polysubstance abuse. We didn't think it was safe to have him come back. The only thing we could do, we can refer him to addiction specialist. We talk to the patient; he was alert and decisional. We do searches on bags and rooms, but we do have limitations. I wasn't informed of the investigation. Refer him to a treatment facility for drug addiction and a psychiatrist. If he was referred to see the psychiatrist by the nurse practitioner and they (nursing) didn't put it in, we	S9999		

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S9999	Continued from page 21 have to see why it wasn't written as an order. Educate our Nurse Practitioners; it has to transfer out to an order." There is no documentation of law enforcement being notified of the illicit drug/unknown substance being found in the facility. Review of the investigation documents identifies multiple witness statements are the same and do not reflect staff working directly with R3 during the 9/19/25 and 9/25/25 incidents. Nursing statements by V13 LPN Licensed Practical Nurse reflect the progress note already written in R3's medical records. There is no witness statement from V28 CNA Certified Nurse Assistant working 7AM - 3PM and V27 LPN working 11PM - 7AM on 9/18/25. There are no witness statements from V24 CNA and V29 LPN Wound Nurse who witnessed the incident with R3 on 9/19/25. There is no witness statement from V32 CNA, V33 CNA, and V27 LPN working 11PM - 7AM on 9/24/25 prior to R3's incident during the morning of 9/25/25. There is no witness statement from V28 CNA working 7AM - 3PM on 9/25/25. There is a statement from V34 RN Registered Nurse and V35 CNA for 9/25/25 on which both staff worked the 3PM-11PM shift. V34 RN and V35 CNA were not working during the incident with R3 which happened on the 7AM-3PM shift upon review of the timecards. There is a statement from V34 RN Registered Nurse and V30 CNA from 10/3/25. Review of the timecards and daily schedule indicate they did not work on 10/3/25. V30 CNA worked 3PM-11PM on 10/3/25 after R3's incident during 7AM-3PM shift. V30 was not working during the incident. There is a statement from V34 RN Registered Nurse and V30 CNA from 10/3/25. Review of the timecards and daily schedule indicate they did not work on 10/3/25. V35 CNA worked 3PM-11PM on 10/3/25 after R3's incident during 7AM-3PM shift. V35 was not working during the incident. V35's 9/25 and 10/3 witness statements document the same information. Resident Possession and Use of Illegal Substances policy states: Policy: It is the policy of this facility to uphold the resident's right to retain and use personal	S9999		

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S9999	Continued from page 22 possessions, unless to do so would infringe upon the rights or health and safety of other residents. The possession and use of illegal substances by residents will not be tolerated. Policy Explanation and compliance Guidelines: 1. Facility staff will have knowledge of signs, symptoms, and triggers of possible illegal substance use, which includes but is not limited to: a. Changes in behavior, b. Increased, unexplained drowsiness, c. Lack of coordination, d. Slurred speech, e. Mood changes, f. Loss of consciousness. 3. If the facility determines through observation that a resident may have access to illegal substances that they brought into the facility or secured from an outside source, the facility will not act as an arm of law enforcement. 4. To protect the health and safety of residents, the facility will provide additional monitoring and supervision, which includes denying access or providing supervised visitation to individuals who have a history of bringing illegal substances into the facility. 4. If facility staff identified items or substances that pose risks to residents' health and safety and are in plain view, they will confiscate them. 5. Facility staff will not conduct searches of a resident or their personal belongings, unless the resident or resident representative agrees to a voluntary search and understands the reason for the search. The 5/2025 Contraband Policy states: Policy: This organization reserves the right to conduct inspections if there is a reason to suspect/believe that a resident has contraband items/materials in his/her possession. This includes egregious actions such as secretly (and illegally) recording other persons. These items include, but are not limited to, alcohol, illicit (street or over the counter) drugs, weapons (including any sharp objects/ammunition), and smoking materials (if the individual has assessed as dangerous and irresponsible with smoking related items). The organization will try to balance individual rights against the safety needs of peers, visitors, and staff members in making decisions about further investigation of contraband. In situations where illegal activity appears to have taken place appropriate authorities will be notified. Again, safety	S9999		

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S9999	Continued from page 23 and security are of the utmost concern. Room and "Person" Search Policy The following items are NOT ALLOWED in resident rooms at any time and are not allowed on the resident's person unless permission has been granted from administration and supervision is being provided: Drugs, Drug Paraphernalia. The August 2023 Substance Abuse Policy states: Substance Abuse Policy The facility reserves the right to protect all residents, staff, and visitors from the negative effects of substance abuse. The facility will take all precautions necessary to prevent residents from using alcohol or illegal substances. 1. In the event a resident is suspected of drinking alcohol or using drugs the facility will immediately, medically, and behaviorally assess the resident to verify if hospitalization is needed. 2. The resident will be given a drug screen to indicate the specific substance ingested. 3. The resident's pass will be immediately suspended pending results of the drug screen. 4. The resident will be restricted from attending day program (as applicable) pending the drug screen. 5. Refusal to take drug screen is identified as an automatic positive. Upon receiving positive results from a drug screen, the following protocol will be followed: 1. Any passes will be restricted for 30 Days. Passes will be reinstated at the discretion of the Administration Team. 2. The resident will be suspended from the day program (as applicable) at the discretion of the Administration Team. After two weeks, the Administration Team will assess if the resident is ready to return to the day program. 3. Home passes with family will be restricted at the discretion of the administration. After two weeks, the administration team will assess the resident's progress to determine if the resident is appropriate to go home with family.	S9999		

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S9999	Continued from page 24 4. The resident will be placed on a behavior contract coinciding with their specific substance abuse issues and treatment plan. Resident Signature/date: Staff/Witness Signature/Date (A)	S9999		