STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145211	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thryve of Burbank	5400 West 87th Street Burbank, IL 60459

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 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 the daily staffing posting was completed appropriately. This failure has the potential to affect all the 123 residents at the facility.Findings include:The (04/13/20260 midnight census report documented that there were 123 residents at the facility. The (04/01/2026 - 04/13/2026) Daily Staffing posting did not include the daily resident census. On 04/13/2026 at 2:41pm, V9 (Staffing Director) stated, the ?reception' is in charge of filling out the Daily Staffing Posting. V9 stated she provides the daily schedule to receptionist every morning between 6:30am - 8:00am. This surveyor presented to V9 the 04/01/2026 - 04/13/2026 Daily Staffing Posting and inquired what is missing. V9 stated the residents census is not filled out; the regulations stated to include the resident census. V9 stated the purpose of the Daily Staffing Posting is to make everyone, including visitors, aware of the staffing at the facility. The Daily Staffing Posting should be completely filled out daily. The (1/2/2026) Nurse Staffing Posting Information documented, in part Policy: It is the policy of this facility to make nurse staffing information readily available in a readable format to residents, staff, and visitors at any given time. Policy Explanation and Compliance Guidelines: l. The Nurse Staffing Sheet will be posted on a daily basis and will contain the following information: a. Facility name. b. The current date. c. Facility's current resident census. d. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: i. Registered Nurses. ii. Licensed Practical Nurses/Licensed Vocational Nurses. iii. Certified Nurse Aides.

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
	145211	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thryve of Burbank	5400 West 87th Street Burbank, IL 60459

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure unused isolation gowns were not hanging inside the sorting area of the soiled linen room and failed to ensure contaminated material did not cross over the clean area in the laundry room in an effort to prevent spread of infection. These failures affected 2 (R6 and R7) residents reviewed for infection control and have the potential to affect all the 123 residents at the facility. Findings include:The (04/13/20260 midnight census report documented that there were 123 residents at the facility. On 04/13/2026 at 12:23pm by the Laundry's Soiled Linen room, there were 2 yellow isolation gowns hung by the sorting area. On 04/13/2026 at 12:28pm by the dryers inside the laundry's clean area, there was a paper stuck between the drum and the door of the 2 dryers; one paper contained R6's name and room number, and the other paper contained R7's name and room number. V6 (Laundry Aide) stated she got the paper from the resident soiled linen clothing and stuck them between the drum and the door of the dryer so she knows to whom the clothing belongs to. On 04/13/2026 at 12:44pm, V5 (Housekeeping/Laundry Supervisor) stated he started as Supervisor in March of 2025, and it has been the practice of putting the paper which contained the name and room number of the resident between the door and the drum of the dryer. V5 stated staff does know what is in the resident's clothing and the residents clothing could be contaminated with something that they don't know. V5 stated best practice is to not bring the paper with the resident's name and room number in the clean area of the laundry room.On 04/13/2026 at 1:56pm, V8 (Laundry Aide) stated he has been at the facility for 2 1/2 years and he has been putting the paper with the resident's name and room number back to clean resident's clothing. V8 stated he is now seeing an issue for cross contamination. V8 stated he is now instructed to throw away the contaminated paper and write the name and room number of the resident on a fresh uncontaminated paper which is the smartest thing to do. On 04/14/2026 at 12:05pm inside the soiled linen room, there were 2 yellow disposable isolation gowns hung by the sorting area. V5 stated he did not know how and when the aides used the isolation gowns.On 04/14/2026 at 12:10pm, V6 stated she removes the paper inside the resident soiled clothing plastic bag, puts the resident's clothing in the washer and puts the paper which contained the resident's information on top of the washer so she knows to whom the clothing belongs to and once the resident's clothing are washed, she places the paper between the drum and door of the dryer for the same reason, to know whom the clothing belongs to. On 04/15/2026 at 10:12am, V6 stated she prepared 2 unused isolation gowns by hanging them in the sorting area of the soiled linen room. V6 stated she is the only aide during the morning, and she wanted to save time by hanging the isolation gowns inside the sorting area. V6 stated she would wear one of the isolation gowns, sort the dirty linens and dispose of the isolation gown after. V6 stated she donned the remaining isolation gown if she had to sort soiled linens again and it has been her practice for 38 years. V6 stated she began placing the paper with the resident's information between the door and drum of the dryer when facility no longer provided mesh bag for the resident's dirty clothing. V6 stated she could not recall when, but it was long time ago.On 04/14/2026 at 1:12pm, V2 (Director of Nursing) stated the soiled area in the laundry room is where the washers are located and the clean area is by the dryer where they fold the clean linens. It is not okay for the contaminated paper to cross over the clean area of the laundry room because it cause cross contamination. It has the potential to affect all the residents at the facility. On 04/15/2026 at 10:31am, V2 (Director Of Nursing) stated the expectation is not to prepare the isolation gown and hang them inside the sorting area to save time; it should not be that way because facility did want to contaminate her uniform when she wears the unused isolation gown and then she goes to the clean area of the laundry room which can potentially cross contaminate the clean area of the laundry room. V2 stated for her protection, her family's and the residents' protection, she should not hung the clean isolation gown in the soiled linen room's sorting area. This practice could potentially affect all residents at the facility.On 04/15/2026 at 10:40am, V1 (Administrator) stated in the laundry room, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145211	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thryve of Burbank	5400 West 87th Street Burbank, IL 60459

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	there is a clean area and dirty area. The dirty area should be separated from the clean area. Contaminated materials from the dirty area of the laundry room should not cross over the clean area to prevent cross contamination, for infection control. The paper which contained the resident's information inside the resident's dirty clothing should not cross over the clean area of the laundry room. V1 stated isolation gowns used for sorting dirty linens should not be hung in the sorting area. These isolation gowns are considered dirty. The purpose is to prevent contamination. R6's admission Record documented that R6's diagnoses include but are not limited to encounter for attention to colostomy, acute respiratory failure, and pulmonary nodule. R6's (01/14/2026) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 15. Indicating R6's mental status as cognitively intact. R6's (Active Order as Of: 04/13/2026) Order Summary Report documented, in part Enhanced Barrier Precautions. Active: 11/04/2024. R6's (Target Date: 07/02/2026) care plan documented, in part requires Enhanced Barrier Precautions d/t (due to) Colostomy. Enhanced Barrier Precautions will reduce the spread of the infectious agent, minimize the transmission of the infection, and reduce the risk of colonization. Follow facility's Infection Control and Enhanced Barrier Precautions policies/procedures when cleaning/disinfecting room, handling soiled and/or contaminated linen. R7's admission Record documented that R7's diagnoses include but are not limited to Type 2 Diabetes Mellitus, ileostomy status, and hypertension. R7's (03/31/2026) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 15. Indicating R7's mental status as cognitively intact. R7's (Active Order as Of: 04/13/2026) Order Summary Report documented, in part Enhanced Barrier Precautions. Active: 09/06/2024. R7's (Target Date: 06/26/2026) care plan documented, in part requires Enhanced Barrier Precautions d/t (due to) Colostomy. Enhanced Barrier Precautions will reduce the spread of the infectious agent, minimize the transmission of the infection, and reduce the risk of colonization. Follow facility's Infection Control and Enhanced Barrier Precautions policies/procedures when cleaning/disinfecting room, handling soiled and/or contaminated linen. The (1/2026) Linen/Laundry Handling documented, in part Guidelines: The facility promotes the control of infections through the use of Standard Precautions while handling linen. Procedure: 5. Employees will wear appropriate PPE (personal protective equipment) when handling contaminated linen. (gloves and gowns in the laundry area). The (4/2/2026) Personal Protective Equipment documented, in part This facility promotes appropriate use of personal protective equipment to prevent transmission of pathogens to residents, visitors, and other staff. Definitions: Personal protective equipment, or PPE, refers to a variety of barriers used alone or in combination to protect mucous membranes, skin, and clothing from contact with infectious agents. It includes gloves, gowns, face protection (facemasks, goggles, and face shields), and respiratory protection (respirators). Policy Explanation and Compliance Guidelines: l. All staff who have contact with residents and/or their environments must wear personal protective equipment as appropriate during resident care activities and at other times in which exposure to blood, body fluids, or potentially infectious materials is likely. 2. PPE will be utilized as part of standard precautions regardless of a resident's suspected or confirmed infection status. 3. Multiple factors determine the appropriate selection of PPE for a particular task: a. The type of exposure anticipated (e.g., splash/spray versus touch)b. The volume of fluid or tissue to which there is a potential exposure. c. The likelihood of exposure. d. The probable route of exposure (e.g., direct contact versus inhalation). 4. Indications/considerations for PPE use: b. Gowns: 1. Wear gowns to protect arms, exposed body areas, and clothing from contamination with blood, body fluids, and other potentially infectious material.The (undated) Laundry Aide Job Description documented, in part Basic Function: To handle and process laundry using proper policies and procedures. Essential Duties: 1. Label laundry per the facility procedures. 3. Sorts, washes, dry, folds and handles laundry using proper procedures. 5. Eliminates crossing of soiled and clean linen.8. Maintains a clean work and storage area. 13. Follows proper infection control practices.