

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145460	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2025
NAME OF PROVIDER OR SUPPLIER Thrive of Lake County		STREET ADDRESS, CITY, STATE, ZIP CODE 850 E US Highway 45 Mundelein, IL 60060	
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 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 interview and record review, the facility failed to ensure a resident was safely turned and positioned during incontinence care for 1 of 4 residents (R1) reviewed for safety and supervision in the sample of 4. The findings include: R1's admission Record, dated 11/19/25, shows R1's diagnoses include, but are not limited to type 2 diabetes, morbid obesity, presence of a cardiac pacemaker, hypertension, polyneuropathy, restless and agitation, and a history of falling. R1's Minimum Data Set, dated [DATE], shows R1 has impairment to her functional range of motion on one side to her lower extremity (hip, knee, ankle, foot), has moderate cognitive impairment and is dependent (meaning the helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of two or more helpers is required for the resident to complete the activity.) on staff to provide toileting hygiene and to roll left and right (the ability to roll from lying on back to left and right side and return to lying on back on the bed.). R1's current care plan provided by the facility shows R1 has ADL (activities of daily living) self-care performance deficits and limitations in physical mobility and has a history of being resistant to care such as refusing to be changed, uncooperative and resistant to treatments due to agitation. R1's care plan shows she is at high risk for falls due to her debility/need for assistance with ADLs and acute illness. R1's Progress Notes written on 11/17/25 at 1:45 AM by V6, Licensed Practical Nurse (LPN), shows the CNA, V7, called V6 to R1's room where R1 was lying on her left side on the floor on the right side of the bed. V6 said she was told by V7 the following, while changing this resident, I positioned her on her right side, and told her not to turn any further, I proceeded to clean her when I noticed she started sliding down the right side of the bed, so I grabbed the draw sheet in an attempt to prevent her from falling but I was unable and instead assisted in guiding her down to the floor, she landed on her left side without hitting her head. The facility's State Report regarding R1, dated 11/19/25, shows R1 had a witnessed fall on 11/17/25. It shows R1 has a history of falling and non-compliance with medication and refusing treatment and care. R1's After Visit Summary from the hospital, dated 11/17/25, shows R1's height is five feet five inches, and her weight is 283 pounds 4.7 ounces. R1 had a CT scan of her cervical spine, abdomen, pelvis and head and x-rays of her left knee and was diagnosed with a fall. On 11/19/25 at 9:57 AM, R1 said on Monday night (11/17/25) around 1:30 AM, a female CNA (Certified Nursing Assistant) whose name she cannot remember was changing her. R1 said the CNA, later identified as V7, was rolling her onto her right side and all the sudden said, Don't move, or you're gonna (sic) fall off the bed and no sooner than she said it, she had already fallen out of bed onto her knees. R1 said she didn't actually fall, she was pushed. R1 said V7 called for help and a nurse came. R1 said she was taken to the hospital, and she returned the same night with a bruised knee. R1 showed her left knee which had a light green half dollar coin sized bruise. R1 said there were no fractures or other injuries. On 11/19/25 at 12:06 PM, V5, CNA, said R1 is a two assist for turning in bed; she is heavy. On 11/19/25 at 12:14 PM, V2, Director of Nursing (DON), said that during care, the CNA (V7) had R1 turned to her side and R1 kept shifting herself. The CNA asked R1 to stay still so she could clean her, but the resident shifted again and started to slowly slide down the bed. The CNA grabbed the sheet to keep the resident from falling, but couldn't stop the fall, so the (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA lowered R1 slowly to the floor. V2 said the ADON (V3 -Assistant Director of Nursing) spoke to R1 and they updated her care plan and added education on body position and alignment in bed. On 11/19/25 at 12:23 PM, V7 said she was changing R1 and had R1 turned to her right side, and she was behind her on the left side of the bed. V7 said R1 was scooting toward the edge of the bed, and she told R1 to stop scooting because she was going to fall, but R1 scooted a little and she could see R1's legs going over the edge of the bed. She reached for R1 to keep her from falling, but couldn't get her stopped in time, so she grabbed her by the waist and eased her down towards the floor and R1 ended up on the floor. V7 said R1 can help turn her upper body but needs help crossing her (left) leg over to turn her lower body. V7 said if there were two people in the room, it would have prevented the fall. V7 said after R1 fell, she now uses two people to turn R1. On 11/19/25 at 2:38 PM, V6 said V7 yelled for help from R1's room. When she entered R1's room, she noted R1 on the floor. V6 said V7 told her she was changing R1 and told R1 to roll over to her side, then her legs went too far over the side and R1 started to slide down, so V7 grabbed the sheet to stop the fall, but wasn't able to, so she guided R1 and the sheet to the floor.		