STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145460	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thrive of Lake County	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36186 Based on observation, interview and record review the facility failed to maintain a resident's dignity during personal care. This applies to one of one residents (R66) reviewed for dignity in the sample of 32. The findings include: The facility face sheet shows R66 was admitted to the facility with diagnoses to include dementia, hemiplegia (loss of motor skills on one side of the body) and chronic pain. The facility assessment dated [DATE] shows R66 to have severe cognitive impairment and is dependent on staff for toileting. On 3/11/2025 at 12:00 PM, R66 was heard telling staff she needed to use the bathroom. V11 CNA (Certified Nursing Assistant) and V12 Social services took R66 into her room and using the mechanical lift assisted her into bed. R66 said, When am I going to the toilet?. V11 said to R66, it's OK to just go in your brief and I promise I'll come clean you up. I'll leave so you can have some privacy. R66 was later heard yelling, Help me! Help me! On 3/12/25 at 1:49 PM, V11 CNA said she wasn't sure if there were any bedpans on the unit and if there was she would have offered R66 the bedpan. V11 said she knew R66 needed to have a bowel movement and that was why she gave her privacy. On 3/12/25 at 1:30 PM, V15 ADON said when a resident can not use the toilet, a bedpan should be offered. V15 said it's important to maintain a residents dignity and the staff should never tell a resident to just go to the bathroom in their brief. On 3/13/25 at 1:07 PM, V2 Director of Nursing said a resident should never be told to have a bowel movement in their brief, they should be offered the bed pan. The facility policy for dignity dated November 2011 shows the facility will promote care for elders of the facility in a manner and in an environment that maintains and enhances each residents dignity and respect in full recognition of the residents individuality.

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: 145460	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
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(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** 36186 Based on observation, interview and record review the facility failed to transfer a resident in a safe manner. This applies to one of eight residents (R66) reviewed for safety in the sample of 32. The findings include: The facility face sheet shows R66 was admitted to the facility with diagnoses to include dementia, hemiplegia (loss of motor skills on one side of the body) and chronic pain. The facility assessment dated [DATE] shows R66 to have severe cognitive impairment and is dependent on staff for transfers. On 3/11/25 at 12:00 PM, R66 was asking to go to the bathroom. V11 CNA (Certified Nursing Assistant) and V12 Social Services took R66 to her room and brought in the mechanical lift. V11 attached the hoops of the sling to the lift and began lifting R66 up. V12 was behind V11 at the entrance to the room. V12 was not near R66 during the transfer of R66. V11 lifted R66 and pushed her away from the wheelchair over to her bed, V11 then asked V12 to help guide her legs. V12 then came close to the resident but R66 was already over the bed and was being lowered to the bed. On 3/12/25 1:29 PM, V15 ADON (Assistant Director of Nursing) said she believes all staff are trained in using the mechanical lift when they are hired. V15 said there should be two staff present when the transfer happens. One staff to guide the resident and one staff to run the lift. On 3/12/25 at 1:52 PM, V11 said V12 always helps with the mechanical lifts and the whole team works together. On 3/12/25 at 2:43 PM, V12 said he thinks he was trained about the mechanical lift when he was hired but there were a lot of things he got trained on. V12 said he is only allowed to supervise the transfer, he can not touch the residents. On 3/13/25 at 11:02 AM, V14 Restorative Nurse said two staff are needed for a mechanical lift transfer for safety reasons. One staff is to be at the feet and one staff at the residents head. All staff are trained on hire and a competency test is done yearly. V14 said even though V12 is not allowed to touch the resident, if a situation came up where he would have to touch the resident for safety reasons he could. On 3/13/25 at 12:20 PM, V13 CNA, said two people are needed for a mechanical lift transfer, one to guide the resident and one to guide the lift for safety reasons. On 3/13/25 at 1:05 PM, V2 Director of Nursing said there should be two staff for mechanical lift transfers for the safety of the residents. V2 said both staff should be standing near the resident during the transfer so they can reach out and help the resident if needed. The care plan for R66 dated 7/17/2022 shows the intervention to have two staff assist for mechanical lift transfers. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy for mechanical lift transfer with a revision date of March 2024 shows at least two staff are required to be present to transfer a resident when using a mechanical lift.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34491 Based on observation, interview and record review, the facility failed to ensure a dressing change and measurement of an IV PICC (a peripherally inserted central catheter) line's external catheter was completed for 1 of 1 resident (R15) reviewed for PICC lines in the sample of 32. The findings include: R15's Admission Record, provided by the facility on 3/13/25 showed she had diagnoses including, but not limited to, severe protein-calorie malnutrition, Guillain-Barre Syndrome, anxiety disorder, depression, chronic kidney disease, a personal history of transient ischemic attack (TIA-stroke), cerebral infarction without residual deficits, and heart failure. R15's Order Summary Report, provided by the facility on 3/13/25, showed the following orders were received on 2/7/25: IV PICC line (a thin, flexible tube inserted into a vein in the upper arm and threaded into a large vein near the heart for long-term intravenous infusions of medications, fluids, or nutrition) change dressing every 7 days-with a start date of 2/14/25. IV PICC line measure external catheter length with dressing change every 7 days- with a start date of 2/14/25. R15's care plan initiated on 12/9/24 showed she required TPN (Total Parental Nutrition) for adequate nutrition and hydration status. R15's care plan initiated on 12/9/24 showed she is receiving IV medication(s). The care plan showed IV dressing: Observe dressing every shift. Change dressing and record observations of site weekly. R15's facility assessment dated [DATE] showed no behaviors of rejecting care. The assessment showed R15 had moderate cognitive impairment. The assessment showed R15 was receiving Parenteral/IV feedings, and had a mechanically altered diet. On 3/13/25 at 1:03 PM, V22 (Licensed Practical Nurse-LPN) went with this surveyor to look at R15's PICC line. R15 had an IV PICC line on her left upper arm. The bottom of the dressing that covered the PICC line was not intact. No date was on the dressing showing when the dressing was last changed. R15 said it had not been changed for a while. On 3/13/25 at 1:07 PM, V2 (Director of Nursing-DON) went with this surveyor to look at R15's PICC line. V2 verified there was no date or signature on the dressing, and the bottom of the dressing was not intact. At 1:09 PM, V3 (Assistant Director of Nursing-ADON) brought R15's Treatment Administration Record (TAR) up on the computer located on the nurse's medication cart. V3 clicked on the dressing change order, and on the order to measure the external catheter length. V2 said both showed the last time they were signed off as being completed was on 2/28/25 (13 days prior). V2 said it is important to change the PICC line dressing every week for infection control. At 1:39 PM, V2 said it is important to measure the length of the external catheter on the PICC line to ensure proper placement of the PICC line. R15's February 2025 TAR was reviewed showing the dressing change and the length of R15's external catheter were completed on 2/28/25. R15's March 2025 TAR showed the next dressing change and measurement of the external catheter should have been completed on 3/7/25. On 3/7/25, no nurse signed off as having completed the dressing change or doing the measurements. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Thrive of Lake County		STREET ADDRESS, CITY, STATE, ZIP CODE: 850 E US Highway 45 Mundelein, IL 60060	

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's November 2020 policy and procedure titled Central Line Care showed Peripherally Inserted Central Catheter (PICC) line care dressing change, maintenance and removal will be completed according to standard of practice by Licensed Nurses only .All PICC line treatments and dressings require a physician order .Following the initial 24 hour dressing change, an RN (Registered Nurse) or LPN (Licensed Practical Nurse) will change the injection cap and the dressing at minimum weekly or anytime the dressing becomes moist, loosened or soiled. The procedure showed Label dressing with date dressing was changed, if PICC line is sutured or non-sutured, and the initials of nurse who changed dressing and the date of dressing change.

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F 0697

Level of Harm - Actual harm

Residents Affected - Few

Note: The nursing home is disputing this citation.

Provide safe, appropriate pain management for a resident who requires such services.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45395

Based on interview and record review, the facility failed to ensure a resident's pain medications was provided for 1 of 2 residents (R133) reviewed for pain management in the sample of 32. These failures resulted in R133 experiencing unrelieved pain and was not unable to fully obtain restful sleep for three days.

The findings include:

On 03/11/25 at 10:35 AM, R133 said for the last 3 nights on the 8th through the 10th, she did not receive her muscle relaxer (tizanidine) as requested and indicated she needed that the most because she usually takes the muscle relaxer with norco in the morning and at night. R133 was told by staff that the medication was ordered, and they would follow-up with pharmacy. She said that no one followed up with her regarding the status of the medication. R133 then said the muscle relaxer came last night (03/10/2025) and that she received the medication this morning (03/11/2025). R133 added that V4 (Licensed Practical Nurse) told her that he had reordered the medication when there was 5 pills left.

Review of R133's medication administration record for January 2025 showed R133 was administered tizanidine 2mg tablet on the 1st-5th, 8th, 10th-14th, 16th-19th, 21st-24th, 26th-28th, and the 30th.

Review of R133's medication administration record for February 2025 showed R133 was administered tizanidine 2mg tablet on the 1st-3rd, 7th, 9th, 11th, 13th-16th, 18th-19th, 21st, 23rd-26th, and the 28th.

Review of R133's medication administration record for March 2025 showed R133 was administered tizanidine 2mg tablet on the 1st-2nd, 5th-9th, and the 11th-12th.

Review of R133's pain assessments for last 3 months showed that during the 3 days resident said she did not receive her muscle relaxer (tizanidine), a pain level of 5 was documented on 03/08/2025 at 08:57 AM and on 03/09/2025 at 08:58 AM. Pain levels of 8 were documented on 03/10/2025 at 09:39 AM and 09:42 AM, and a pain level of 5 was documented on 03/10/2025 at 08:04 PM. Pain level of 7 was documented on 03/11/2025 at 08:08 AM

On 03/12/25 at 01:52 PM, surveyor informed resident that medication administration record showed she was administered the medication on 03/08/2025 and 03/09/2025. R133 became visibly upset then said, that's a damn lie. R133 again indicated that she did not receive her muscle relaxer from the 8th through the 10th, and finally received her muscle relaxer on 03/11/2025.

Review of R133's medical record indicated resident last admitted to the facility on [DATE] with a past medical history not limited to: hypertension, bilateral osteoarthritis of knee, other specified postprocedural states, morbid obesity, and muscle weakness.

Review of R133's care plan documented resident has the potential for pain initiated on 11/18/2024 with interventions that included but not limited to anticipate the resident's need for pain relief and respond immediately to any complaint of pain.

(continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R133's Minimum Data Set (MDS) dated [DATE] documented in Section C for cognitive patterns that R133 has no cognitive impairment with an assessment score of 15/15. Section J for health conditions documented R133 requires pain management and receives scheduled and as needed pain medications. Review of R133's active orders as of 03/13/2025 showed orders for pain evaluation every shift, hydrocodone-acetaminophen (norco) 5-325 milligram (mg) tablet every 8 hours as needed for pain, and tizanidine hcl 2mg tablet every 8 hours as needed for muscle spasm. On 03/12/2025 at 01:52 PM, R133 who appeared visibly distraught said when she didn't take her muscle relaxer medication (tizanidine) with norco for those 3 days (3/8-3/10/2025), her pain was not fully controlled, and she was having muscle spasms to the front of her legs which made it hard for her to sleep during those 3 days. R133 said she had asked for the tizanidine several times but was told by the nurses that she didn't have any left and could only get norco. At 01:56 PM, R57 (R133's roommate) said a few mornings ago, she was awoken by R133 who was moaning out loudly in her sleep. R57 then said, I felt so bad for her (R133) because I knew she was hurting bad. On 03/13/2025, review of R57's Brief Interview for Mental Status (BIMS) Evaluation dated 02/4/2025 indicated R57 has no cognitive impairment/ intact cognitive response with assessment score of 15. On 03/12/2025 at 02:05 PM, V5 (Licensed Practical Nurse) said R133 usually requests her tizanidine medication (muscle relaxant) daily in the morning and at night. V5 then said R133's tizanidine medication was reordered last on 03/08/2025 and 15 capsules were received on 03/10/2025. Reviewed R133's medication card for tizanidine with V5 that showed a dispensed date of 03/10/2025. On 03/13/2025 at 11:11 AM, V4 (Licensed Practical Nurse) said that he reordered R133's tizanidine medication on 03/04/2025 and R133 had 3 or 4 capsules left on her medication card when he reordered. On 03/13/2025 at 01:00 PM, V2 (Director of Nursing) said her expectation of staff is to manage a resident's pain by administering their pain medication as ordered and as needed. V2 added that staff should reorder a medication when there's a week's supply left and if a medication is unavailable, they should utilize the facility's automated medication dispensing system. On 03/13/2025, review of facility's automated medication dispensing system list of supplied medications did not include the medication tizanidine. V1 (Administrator) also provided in-service records dated 03/12/2025 and 03/13/2025 for medication administration. On 03/13/2025 at 01:43 PM, surveyor requested from V1 (Administrator) the contact information for V23 (Registered Nurse) to clarify her documented administrations of tizanidine to R133 on 03/08/2025 and 03/09/2025 during the 3 days that R133 was told she had none left and had previously indicated not receiving the medication. V23's contact information was not provided during survey or upon survey team exiting the facility. On 03/13/2025, facility provided order detail report for R133's tizanidine medication that documented 3 capsules were dispensed on 03/03/2025 then medication was not dispensed again until 03/10/2025 with 15 capsules dispensed on the same date. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Administration of Medications policy last revised 02/2018 reads in part: all medications are administered safely and appropriately to aid residents to and help in overcome illness, relieve and prevent symptoms and help in diagnosis .if a medication is ordered but not available, check to see if it was misplaced and then call the pharmacy to obtain the medication . Pain Management policy last revised 10/2024 reads in part: to ensure the resident's pain is managed effectively. It is the policy of this facility to respect and support the resident's right to optimal pain assessment and management. This facility recognizes that residents may have decreased sensations or perceptions of pain .Chronic pain may produce anorexia, lethargy, depression, immobility, social isolation .Each and every resident has a right to the assessment and management of pain. Effective pain management can remove the adverse psychological and physiological effects of unrelieved pain. Optimal management of the resident experiencing pain enhances the healing and promotes both physical and psychological wellness.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 39537 Based on observation, interview, and record review the facility to ensure medications were administered as prescribed. There were 31 opportunities with 2 errors, resulting in a 6% error rate. This applies to 1 of 2 residents (R264) observed in the medication pass. The findings include: On 3/12/25 at 9:10 AM, V7 (LPN - Licensed Practical Nurse) administered R264's 9 AM medications including amiloride 5 mg, celecoxib 200 mg, ezetimibe 10 mg, folic acid 1.5 mg, zinc 220 mg (V7 administered 225 mg dose), multivitamin, a liquid protein supplement, pregablin, vitamin C, and Norco 10/325 mg. V7 did not prepare or administered R264's Thiamine 100 mg tablet. V7 looked through the medication cart for R264's Zinc 220 mg capsules. V7 was unable to locate the medication. V7 held up a Zinc 50 mg tablet and stated, This is all I have, so I'll give 4 tablets to equal 200 mg and I'll cut a fifth tablet in half to make 25 mg. It's the best I can do. I know it's not exactly 220 mg. V7 administered 225 mg of Zinc tablets as he described. V7 did not check the medication room for Zinc 220 mg capsules and he did not call a nursing manager to request Zinc 225 mg capsules. R264's Facesheet dated 3/13/25 showed he was admitted to the facility 3/4/25. This document showed R264 had diagnoses to include, but not limited to: benign lipomatous neoplasm (non-cancerous fatty tumors), encounter for surgical aftercare following surgery on the nervous system, hypertrophied, anemia, disorder of the autonomic nervous system, alcohol dependence and withdrawal, seizures, history of falling, generalized muscle weakness, need for assistance with personal cares, and cognitive communication deficit. R264's Physician Order Sheet dated 3/13/25 showed orders for Thiamine 100 mg daily and Zinc 220 mg capsule - Give 1 capsule by mouth daily. R264's Progress Notes did not have an entry addressing the problem with the Zinc. On 3/13/25 at 9:44 AM, V5 (LPN) was standing next to the medication cart. The surveyor asked V5 if the facility carried the Zinc 220 mg capsules. V5 replied, I think we have the 50 mg tablets. If a resident has an order for 220 mg capsules then the family may bring it in. The surveyor asked V5 how she would prepare a 220 mg dose of zinc with 50 mg tablets. V5 stated, Well, you could give 4 tablets to equal 200 mg, but to cutting the 5th tablet to get 20 mg would be hard. I wouldn't give 225 mg, that's not what was ordered and we should follow the physician orders. I would have called the supervisors to ask if we had 220 mg capsules. If the medication was not available, then I would notify the provider and ask them to change the dose. That should be charted in the progress notes. During this interview, V5 opened R264's EMR (Electronic Medical Record) on the computer. V5 said R264's order was for a 220 mg capsule and she did not see a progress note that the provider had been notified. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/13/25 at 9:50 AM, V20 (Activities/Supplies) said he is responsible for ordering the OTC (Over the Counter) medications or house stock. V20 said the nurses or supervisors will notify me if we need to order anything. The surveyor and V20 went to the OTC room. The surveyor asked V20 if the facility had Zinc 220 mg capsules. V20 pointed to a bin with 6 bottles Zinc 50 mg tablets. V20 stated, This is all we have for Zinc. I don't recall the nurses asking me to order Zinc 220 mg capsules. If I need something, then I can usually run over and pick it up the same day. I'll have to check on that. On 3/13/25 at 12:24 PM, V2 (DON - Director of Nursing) said during medication administration the nurses should verify they have the right resident, right medications, and right dosage. V2 said if the nurse was administering the 0900 medications, then they should give all the medications ordered for that time. V2 said if the medication is not administered, then the nurse should chart a reason why and notify the provider and/or the pharmacy. V2 said the nurses are expected to follow the physician orders. V2 said if a medication dose is not available, then the nurse should let the provider know and get permission to administer an alternative. V2 said this communication should be documented in the progress notes. V2 said the facility had Zinc 50 mg tablets and it would be difficult to provide the exact dose of 220 mg (ordered by the physician). V2 stated, We'll make sure it is replaced with the proper med. The nurse should have notified the manager and we could have looked into it. We know it was a problem and we are working to correct it. The facility's Administration of Medications Policy reviewed April 2023 showed, Policy: 1. A physician or nurse practitioner order is required for administration of all medication . Procedure: .7. If there is a discrepancy between the MAR and label, check orders before administering medications . 10. Prepare or pour each dose of medication using appropriate measuring device . 18. If the medication is not administered, record reason on the eMAR and notify physician or nurse practitioner .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 39537 Based on observation, interview, and record review the facility failed to serve food at an appetizing temperature to the residents for 3 of 3 residents (R112, R80, R68) reviewed for appetizing food temperatures in the sample of 31 and 2 residents outside of the sample (R113, R79). The findings include: On 3/12/25 at 10:30 AM, during the Resident Group Meeting the residents said the meals are served late most of the days. They said last night dinner time was supposed to be 5 PM, but the food doesn't arrive until 6 PM. The residents asked the surveyor have you ever had to eat cold food all the time? It's definitely not satisfying and the food tastes different. There is very much a temperature issue with the food here and it's seems like it's been worse this year. The residents said the cold food had been an ongoing complaint of the Resident Council, but the Dietary Manager has yet to attend the meeting. The residents said food is a continuous concern at the facility and all five residents agreed with the concerns and contributed in the discussion. On 3/11/25 at 9:51 AM, V16 (Dietary Manager) said all the food is cooked in the kitchen and served from the steam table in the kitchen. V16 said the food is served from the steam table, placed on carts and taken to the units or dining room. V16 said the CNAs (Certified Nursing Aides) are responsible for passing the trays to the residents and he is unsure how long it takes for all the trays to be passed. V16 said the dietary staff doesn't have much interaction with the residents. V16 aid he was unsure if the facility had a Food Committee. V16 said he thinks the resident's discuss the food in the Resident Council Meetings, but he has not attended. On 3/11/25 at 11:30 AM, V17 (Cook) obtained the food temperatures from the food in the steam table. The first plate of food was placed on the plate at 11:47 AM. The final plate was prepared at 12:54 PM (over an hour later). The last two carts sent out were to the 7000 and 8000 units and the plates were not covered with insulated bottoms and lids. There were no food temperatures taken during this time. The resident trays were organized by their room location. The facility used several carts to load the resident trays. Some of the food was transported in a covered cart, with no insulated lid or bottom, and other carts had insulated lids and bottoms surrounding the residents plates. V18 (Cook) communicated with V17 (Cook) and loaded each plate into the carts. The carts were then transported out to the units, where the CNAs were responsible for passing the trays. On 3/11/25 the noon meal tray line was disorganized and slow. V17 (Cook) and V18 (Cook) were the main staff handling the resident plates. The doors to the carts were left open, as V18 placed each plate onto the tray. These plates did not have any insulated covers around the plates. (continued on next page)

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 03/13/2025
NAME OF PROVIDER OR SUPPLIER: Thrive of Lake County		STREET ADDRESS, CITY, STATE, ZIP CODE: 850 E US Highway 45 Mundelein, IL 60060	

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/13/25 at 9:13 AM, V16 (Dietary Manager) said he has been in the position since September 2024. V16 said he had not attended a Resident Council Meeting. The surveyor asked V16 why some of the resident trays were sent out with insulated covers and others were not. V16 replied, It was a logistics issue. The trays won't properly fit into the 7000 and 8000 carts if we use the insulated covers. We tried that and we had to cut the number of trays we could fit in the cart in half and the trays weren't as stable with the lids on. I spoke with VP (Vice President) and we are supposed to be getting new carts for 7000 and 8000, so we can use the insulated lids. We have plenty of insulated covers. V16 said the order for new carts was placed last month. V16 said he was aware there were resident complaints of cold food. On 3/13/25 at 9:33 AM, V10 (CNA - Certified Nursing Aide) said the dietary staff deliver the cart with trays to the units, but the CNAs are the ones that have to pass the trays to the resident's V10 said some residents eat in the dining room and others prefer to eat in their rooms. V10 said the CNAs don't have enough time to pass the trays warm and they often have to warm up the residents' food in the microwave. V10 said he only works day shift, but he has to warm several resident plates a day. V10 said the residents complain about the food being cold. On 3/13/25 at 9:38 AM, V19 (CNA) said she the CNAs pass the trays and rarely get help. V19 said dietary never comes out to assist with passing trays. V19 said the residents complain daily about cold food. V19 said some of the residents ask for us to warm their food in the microwave. V19 stated, We spend 30-40 minutes a day heating up trays and that is time we are taken away from resident care.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 39537 Based on observation, interview, and record review the facility failed to ensure dry goods were stored in a manner to prevent cross-contamination, serve food in a manner to prevent cross-contamination, and failed to properly sanitize the food preparation surfaces. These failures affect all residents residing in the facility. The findings include: The CMS 671 Form dated 3/11/25 showed the facility census was 161 residents. 1. On 3/11/25 a kitchen tour was conducted with V16 (Dietary Manager). At 9:47 AM, in the rear of the kitchen (where the facility performs the puree process), on low shelf below the commercial blender there was an open pitcher with approximately 2 inches of a white powder substance. There was not a cover on the pitcher. The surveyor pointed down to the pitcher and asked V16 what was inside. V16 stated, Oh that's thickener. The surveyor asked him if the thickener should be covered. V16 replied, Yes, this is garbage. I'll throw it out. The kitchen tour continued into the dry storage room. There was a large box, with a clear plastic liner open with a white powder exposed. The surveyor walked near the box and the clear plastic liner moved. The surveyor pointed to the box and asked V16 what was in there. V16 said it was thickener and should not be left open due to the risk of things falling into the thickener. It should be covered to prevent cross-contamination. V16 placed the plastic liner over the white powder and closed the top of the box. At 12:56 PM, the box of thickener, in the dry storage room was open to air with the top layer exposed to the air. The surveyor pointed this out to V16 (Dietary Manager) and he turned to the kitchen and asked, Who was in the thickener? The facility's Dietary Food Storage Policy dated December 2020 showed, Policy: Food and non-food supplies will be purchased, received, and stored under safe and secure conditions as required to meet federal, state, and local laws . 2. On 3/11/25 at 11:40 AM, there was a red bucket, on the lower shelf of the food preparation area. The water inside the bucket was dingy and the rag inside was stained a yellow/brown color. V16 (Dietary Manager) said it is the sanitizing bucket for the food preparation area. The surveyor asked V16 to test the sanitization level of the liquid. V16 obtained sanitization test strips that were orange in color. V16 said the strip should change to a yellow/green color or 200-300 parts per million of QAT. V16 submerged the orange test strip into the solution and the color did not change. V16 stated, That's not good. I will have to dump it. V16 said it's important to ensure the sanitizing bucket has the proper amount of sanitizing agent to properly sanitize the food preparation area. V16 said improper sanitization increases the risk for foodborne illness. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Thrive of Lake County		STREET ADDRESS, CITY, STATE, ZIP CODE 850 E US Highway 45 Mundelein, IL 60060	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Dietary Cleaning Policy dated December 2020 showed, Policy: This facility will store, prepare, distribute, and serve food under sanitary conditions to ensure that proper sanitization and food handling practices to prevent the outbreak of foodborne illnesses is attained continuously. Procedures: Staff members preparing food in the kitchen will follow safety precautions to protect the residents and the employees themselves . Staff will use a clean as you go technique to keep the facility and neighborhood kitchen areas clean, functional and attractive . Clean and sanitize work area and dining tables and chairs using sanitizer spray. Clean underside of edge of the tables . 3. On 3/11/25 at 11:44 AM, V17 (Cook) washed his hands then applied purple gloves. V17 approached the steam table to initiate the noon meal tray service. V17 placed his gloved hands behind his back and the back of his hands contacted his clothing. He did not remove the contaminated gloves, but started removing stacks of clean plates from the plate warmer. V17 used the contaminated gloves to obtain a tray of soup bowls. At 11:47 AM, V17 used the contaminated gloves to prepare two pureed plates. Then V17 placed his fisted hands on the ledge of the steam table and leaned into them. V17 had food debris soiled on his apron and pants. Both V17's gloved hands came into contact with his apron and pants. V17 did not remove his contaminated gloves or perform hand hygiene. He continued to touch plates, cups, and bowls with the contaminated gloves. At 11:54 AM, V17 opened the warmer and used his contaminated gloves to obtain a hamburger. He used the contaminated gloves to open a drawer, under the griddle and removed slices of cheese and tomato with his contaminated gloves. V17 assembled the bun, hamburger, cheese with his contaminated gloves and placed the tomato slice on the plate. At 12:00 PM, V17 used the contaminated gloves to open a warmer with insulated bottoms and covers. He opened the latch, obtained these items, and placed them on the counter wearing the same gloves. At 12:08 PM, he returned to the warmer again to obtain insulated bottoms and lids. At 12:15 PM, V17 used the contaminated gloves to retrieve a hotdog bun from the package, then opened to warmer to obtain a hotdog. At 12:30 PM, V17 used the contaminated gloves to search for a utensil in the clean utensil drawer. He moved the utensils about in the drawer with the contaminated gloves. V17 continued placing food on the plates with the contaminated gloves until the final plate was made at 12:54 PM. On 3/13/25 at 9:13 AM, V16 (Dietary Manager) said the cook should change gloves and perform hand hygiene any time their gloves come in contact with their body or clothing. V16 said this important because there is a risk of cross contamination. V16 said the cook's clothes could be dirty or they could have things on their clothes. The facility did not have a policy specific to glove use, hand hygiene, and cross-contamination in the kitchen. The Glove Policy revised 11/2024 did not pertain to use the in the kitchen. The facility's Handwashing Policy dated 11/2024 showed, 1. Handwashing is done before and after resident contact, before and after any procedure, after using a Kleenex or the restroom, before eating and handling food, and when hands are obviously soiled and regardless of glove use .

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NAME OF PROVIDER OR SUPPLIER Thrive of Lake County		STREET ADDRESS, CITY, STATE, ZIP CODE 850 E US Highway 45 Mundelein, IL 60060	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34891 Based on observation, interview, and record review the facility failed to ensure contact isolation precautions were posted (R465), failed to ensure personal protective equipment was worn in enhanced barrier precaution rooms (R157, R16) and failed to change gloves during pericare (R80) to prevent cross contamination for 4 of 5 residents reviewed for infection control in the sample of 32. The findings include: 1. R465's face sheet showed an admitted [DATE]. Diagnoses included acute osteomyelitis of the right ankle (bone infection), MRSA infection (Methicillin resistant staphylococcus aureus), and aftercare following toe amputations. On 3/11/25 at 11:37 AM, R465 had an isolation sign and a PPE bin (personal protective equipment) outside of the door. The sign showed EBP (enhanced barrier precautions) were in place. Gowns and gloves were required only during high-contact resident cares. On 3/12/25 at 9:50 AM, R465 had a new isolation sign outside of the door. The sign showed contact precautions were in place. Gowns and gloves were always required prior to entering the room. On 3/12/25 at 9:54 AM, V6 (Registered Nurse) stated R465 has been on contact isolation since admission. V6 said the sign outside the door should show contact isolation. V6 stated he had no idea why the sign would have been wrong the day before. V6 stated contact isolation is stricter than EBP isolation. Contact isolation is used for more serious infections that are more resistant to antibiotics. Correct PPE helps prevent the spread of germs. R465's physician order report was reviewed and showed contact isolation precaution were started on 3/12/25. On 3/13/25 at 11:07 AM, V2 (Director of Nurses/ Infection Control Preventionist) stated R465 had the wrong type of isolation sign posted on the door. He has surgical wounds and an infection, therefore requires contact isolation. It was an error on our part to have enhanced barrier precautions in place. The facility's Infection Control Policy last review dated 3/2024 states under the contact precautions section: Contact precautions will be used for specified residents known to be suspected or to be infected or colonized with microorganisms that can be transmitted by direct contact with the resident .or indirect contact with environmental surfaces or resident care items in the resident's environment. 2. On 3/13/25 at 10:02 AM, R157 had an isolation sign and PPE bin outside of the room. The sign showed EBP were in place. Gowns and gloves were required during high-contact resident cares. At 10:20 AM, V5 (Licensed Practical Nurse) and V10 (Certified Nurse Aide) entered R157's wearing gloves. V5 and V10 repositioned R157 to the side and opened his incontinence brief. R157 had a wound dressing on his coccyx area. V5 wore gloves while wiping and changing R157's tracheostomy oxygen supply mask. V5 and V10 did not don gowns at anytime during care. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Thrive of Lake County		STREET ADDRESS, CITY, STATE, ZIP CODE 850 E US Highway 45 Mundelein, IL 60060	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/13/25 at 11:07 AM, V2 (Director of Nurses/Infection Control Preventionist) stated staff should be following the isolation precautions posted on the doors. EBP requires gowns and gloves at close, direct resident care. It reduces the risk of infection being transmitted from resident to resident. V2 said R157 has a history of infections and is at high risk for more. The facility's Enhanced Barrier Precautions policy dated 3/2024 states: Gowns and gloves are used during high-contact activities with .changing briefs . tracheostomy/ventilator .any skin opening requiring a dressing . 45395 3. On 03/11/25 at 10:11 AM, surveyor approached R16's room and noted a magnetic enhanced barrier precautions (EBP) sign posted on doorframe that indicated R16 was on EBP for g-tube (indwelling gastrostomy tube), wound, indwelling urinary catheter and colostomy (opening for colon through abdomen) and that staff must wear gloves and a gown for high contact guest care activities that included but not limited to, device care or use of feeding tube. On 03/11/25 at 10:27 AM, surveyor observed V4 (Licensed Practical Nurse) in R16's room at her bedside wearing only gloves and not wearing a gown. V4 said he was preparing to start R16's tube feeding (enteral nutrition) but needed to check placement of R16's g-tube first. V4 then took a syringe from the bedside table, pulled back on the plunger drawing a small amount of air into the syringe, and inserted the syringe tip into the opened entry port of R16's g-tube. V4 placed his stethoscope over R16's left abdominal area and injected the air into the g-tube. After V4 verified placement, he removed the plunger from the syringe and added water into the syringe that drained into R16's g-tube. V4 (Licensed Practical Nurse) then removed the syringe and attached the tip of the tube feeding line into the opened entry port of R16's g-tube then started the feeding pump and performed hand hygiene. On 03/11/25 at 10:30 AM V4 (Licensed Practical Nurse) said he needed to change the dressing around the R16's g-tube insertion site and proceeded to apply gloves, remove the previous dressing, cleansed insertion site area, then placed a new dressing over the insertion site of R16's g-tube. At 10:35 AM, upon V4 (Licensed Practical Nurse) exiting R16's room, surveyor reviewed the posted EBP sign with V4 and when asked if he should have worn an isolation gown while performing g-tube care to R16, V4 (Licensed Practical Nurse) said, yes, I forgot about it. Review of R16's care plan report on 03/11/2025 documented that resident requires tube feeding (g-tube) related to dysphagia and Huntington's disease with date initiated of 05/15/2023. Report also documented that resident is on enhanced barrier precautions related to chronic wounds and g-tube with date initiated of 12/18/2024. R16's active orders as of 03/13/2025 showed orders for enteral feed order ever shift for feeding [nucleolus and neural progenitor protein] 40ml/hr (milliliters per hour) x 18 hours (total volume 720 cc (cubic centimeter) with 200ml flush every 4 hours; enteral feeding order two times a day for feeding stop ta 4:00 AM and restart the feeding at 10:00 AM .; clean g-tube site with normal saline every day shift and as needed for routine care, infection prophylaxis; enhanced barrier precautions: g-tube/wound every shift (12/18/2024). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Thrive of Lake County		STREET ADDRESS, CITY, STATE, ZIP CODE: 850 E US Highway 45 Mundelein, IL 60060	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R16's medication administration record for March 2025 revealed that V4 (Licensed Practical Nurse) documented on 03/11/2025, acknowledgement that R16 is on Enhanced Barrier Precautions for g-tube and wound, he restarted the enteral feeding, and he provided g-tube site care. On 03/13/25 at 11:22 AM, V3 (ADON/Infection Control Nurse) said EBP (Enhanced Barrier Precautions) are extra precautions used for residents with a portal of entry, such as a g-tube. He said the EBP magnet should be posted on the doorway of the residents' room and the isolation bins are outside the rooms. V3 said during g-tube care, the nurse should wear a gown and gloves. He said there is a potential for splashing and contamination of the nurses' scrubs and if something gets splashed on the staff's uniform, they could carry it to another room or they could already have a potential contaminant on their uniform and the g-tube is a portal of entry. This would cause an issue with cross-contamination. V2 (DON) was present during interview and stated, it's been a learning curve for the staff. We've had several training sessions. They should have worn PPE (personal protective equipment) to provide the g-tube care. It's a work in progress. On 03/13/25 at approximately 10:00 AM, V1 (Administrator) provided employee performance form for V4 (Licensed Practical Nurse) that indicated an oral warning was given related to not wearing PPE with a resident on EBP on 03/11/2025. V1 said the facility also conducted an in-service on 03/11/2025 and implemented an audit tool from 03/11 through 03/13/2025 for enhanced barrier precautions procedures that included proper use of PPE. Documents were provided and reviewed by surveyor with no concerns. Enhanced Barrier Precautions policy dated March 2024 reads in part: this facility follows recommendations and guidance from the centers for disease control in order to keep all residents safe from Healthcare Acquired Infections (HAI). Multidrug-resistant-organism (MDRO) transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. On the recommendation and approval of the facility's Infection Preventionist in collaboration with the facility's Medical Director, Enhanced Barrier Precautions (EBP) are implemented as one intervention this facility uses to reduce transmission of resistant organisms that employs targeted Personal Protective Equipment (PPE) use during high contact resident care activities Enhanced Barrier Precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. Indwelling medical device refers to an indwelling medical device provides a direct pathway for pathogens in the environment to enter the body and cause infection. Examples include but are not limited to: central lines .indwelling urinary catheters, feeding tubes .EBP is used in conjunction with standard precautions and expand the use of Personal Protective Equipment (PPE) to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO's to staff hands and clothing. EBP will be used for any residents in this facility who meet the stated criteria wherever the resident resides in the facility. 34491 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Thrive of Lake County		STREET ADDRESS, CITY, STATE, ZIP CODE 850 E US Highway 45 Mundelein, IL 60060	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. R80's Admission Record, provided by the facility on 3/13/25, showed he had diagnoses including, but not limited to, Parkinson's disease, primary generalized osteoarthritis, chronic diastolic congestive heart failure, unsteadiness on feet, low back pain, contracture left knee, type II diabetes mellitus with diabetic neuropathy, dizziness and giddiness, tremors, sciatica right side, and weakness. R80's facility assessment dated [DATE] showed he was cognitively intact, required partial to moderate assistance from staff for getting on and off the toilet, and was dependent on staff for toilet hygiene. R80's care plan initiated on 9/15/23 showed he had episodes of bladder incontinence, and required staff assist to complete toileting task (cleaning/managing clothing). R80's care plan initiated on 6/2/2020 showed he had an ADL (activities of daily living) self-care deficit, required limited assist to transfer, and extensive staff assistance with dressing, toileting, and bathing. On 3/12/25 at 10:04 AM, R80's call light was on. V21 (Certified Nursing Assistant-CNA) entered R80's room. R80 was in his bathroom, sitting on the toilet. V21 performed hand hygiene, put gloves on, grabbed a couple moist wipes and assisted R80 with standing. V21 said she needed to move R80's wheelchair out of the way and used the hand she had the moist wipes in to move the wheelchair back. The moist wipes touched the armrest of the wheelchair, and the cushion on the wheelchair when she was moving it back. V21 used the same wipes to clean R80 after he had a bowel movement. V21 told R80 that he had a good bowel movement. V21 left the gloves on that she used to clean R80's stool with, and pulled up R80's brief, pants, and pulled down R80's shirt. V21 pulled R80's wheelchair closer, touching the right armrest of the wheelchair, then assisted R80 with transferring back to his wheelchair. As R80 was sitting down, V21 place both hands on R80's upper buttocks area, touching his pants and shirt, to help R80 lower into the wheelchair. After getting R80 back into his wheelchair, V21 removed the gloves used for toileting and washed her hands. On 3/13/25 at 11:40 AM, V22 (Licensed Practical Nurse-LPN) said V21 should not have used the wipes if they touched the arm and seat of the wheelchair. They should have discarded the wipes, changed gloves and got a new wipe to clean the resident. V22 said V21 should remove the gloves used for cleaning stool and perform hand hygiene prior to touching the resident's clothes and the environment, to prevent cross-contamination and for infection control. On 3/13/25 at 12:43 PM, V3 (Assistant Director of Nursing-ADON) said V21 should have prepped R80, then grabbed the wipes. V3 said if the wipes touch something, throw them away and get clean wipes for care. V3 said after wiping the resident, V21 should remove the gloves and wash her hands before touching the resident, their clothing, or their environment, to prevent cross-contamination, for infection control. The facility's policy and procedure titled Gloves, with a review date of 11/2024, showed 1. Gloves are worn when there is a chance of coming into contact with excretions, secretions, blood, body fluids, mucous membranes, non-intact skin or other potentially infective material .4. Hands should always be washed after removing the gloves. 5. Gloves are one-time use only item. The facility's policy and procedure titled Handwashing, with a review date of 11/2024, showed 1. Handwashing is done before and after resident contact, before and after any procedure, after using a kleenex or the rest room, before eating and handling food, when hands are obviously soiled and regardless of glove use. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145460	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/13/25 at 2:57 PM, V3 provided the facility's November 2018 policy and procedure titled Incontinence Care. The procedure showed 3. Wash hands and apply gloves. 4. Provide privacy for resident. 5. Remove soiled clothing and linen. 6. Clean peri area with appropriate cleanser and dry. 7. Apply barrier cream if appropriate. 8. Apply clean clothing and linen. 9. Notify housekeeping if floor is wet. 10. Dispose of soiled clothes and linen in appropriate areas. 11. Wash hands . At 2:59 PM, V3 was asked when staff should remove the soiled gloves used to clean stool during care. V3 said staff should remove the soiled gloves after cleaning the resident, and wash their hands before touching the resident or their environment.