STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145718	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thryve of Crestwood	14255 South Cicero Avenue Crestwood, IL 60445

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow policies and procedures; failed to initiate enhanced barrier precautions for a resident; failed to ensure that staff donned the require Personal Protective Equipment (PPE) while providing care for a resident with a known diagnosis of clostridioides difficile (C. diff); failed to perform proper hand hygiene after performing care with a resident with a known diagnosis of C. diff; failed to appropriately clean and disinfect a resident's room with a known diagnosis of C. diff; and failed to ensure soiled linen was securely bagged prior to placement in the laundry chute to prevent contamination and the potential spread of infection. These failures affected two residents (R26 and R210) out of a sample of 63 residents reviewed for infection control and has the potential to affect all 200 residents residing at the facility. Findings include: On 05/06/26 at 9:30AM, V1 (Administrator) stated the facility census is 200 residents residing at the facility. R26's face sheet documents an admission date of 04/21/2026 with diagnoses that include but are not limited to gastrointestinal hemorrhage, ulcerative colitis, colostomy, and enterocolitis due to clostridioides difficile (c. diff). R26's BIMS (brief interview for mental status) score, dated 04/29/2026, is 6 which indicates R26 has severe cognitive impairment. R26's progress note, dated 05/02/2026, documents, in part Resident (R26) continue on Vancomycin 125 mg PO q6H for C-diff stop date 5/10/26. On 5/05/26 at 1:00pm, observed one resident (R26) on transmission-based precautions in the facility. The facility verified R26 is on transmission-based precautions. R26 was in private rooms. R26 is on contact precautions for Clostridioides difficile (C. diff) with two signs on the resident (R26) room door (one for contact-precaution and one for enhanced barrier precaution (EBP). V29 (Unit Manger/LPN/Infection Preventionist) stated R26 is on contact precaution for C. Diff and on EBP for the foley catheter. On 5/05/26 at 1:30pm, V4 (Infection Preventionist/Unit Manager) stated R26's double signage (Contact and EBP) can be confusing. On 5/5/2025 at 5:13pm, V62 (Registered Nurse) was observed entering R26's room which had a contact precautions isolation sign on the door and personal protective equipment (PPE) in the overdoor PPE holder. V62 pushed medication cart in front of door, did not perform hand hygiene, (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	assembled medications, did not perform hand hygiene, entered the room without donning gown or gloves, and administered medication. Surveyor attempted to stop V62 before administering medication, V62 did not respond. V62 exited the room without performing hand hygiene. V62 began to push medication cart to the next room. Surveyor asked V62 about the signage on the door of R26's room. V62 stated I should have used PPE. V62 proceeded to the next room and began assembling medications without performing hand hygiene. On 5/6/2026 at 10:00am, V44 stated that he cleaned R26's room along with all the other rooms in the same hallway earlier using the Neutral Cleaner 15 and Hospital Use Disinfectant-Cleaner and cleaned R26's because R26 is on contact isolation. V44 and V43 stated they use Neutral Cleaner 15 to clean the floors in all rooms and Hospital Use Disinfectant-Cleaner 11 for cleaning high touch surfaces and areas for all rooms. When asked specifically about the cleaning of resident rooms with contact isolation signs, both stated they use Neutral Cleaner 15 and Hospital Use Disinfectant-Cleaner 11 in all rooms including C. diff. rooms. On 5/6/2026 at 10:45am, V43 showed surveyor the housekeeping closet/room where chemical solutions (Neutral Cleaner 15 and Hospital Use Disinfectant-Cleaner 11) were stored. V43 stated that an automated predetermined mixing of solutions is used to fill the mop bucket and spray cleaning bottles that are used to clean resident rooms and hallways. Observed the automated mixture of cleaning and disinfecting solutions. There were no sporicidal solutions or mixtures (cleaners to kill C. diff) in the housekeeping closet/room. On 5/6/2026 at 12:45pm, V43 stated that the rooms like R26's room with a contact precaution sign and knowing the resident has C. diff would still be cleaned with the cleaning and disinfection solutions available to him in the housekeeping closet/room. Upon observation sporicidal solutions were stored in the housekeeping closet/room. On 5/6/2026 at 1:45pm, surveyor inquired to V44 specifically about how rooms with residents on contact precautions with C. diff are cleaned, and V44 replied that V44 would use Neutral Cleaner 15 to clean the floors in all rooms and Hospital Use Disinfectant-Cleaner 11 for cleaning high touch surfaces and areas. V42 (Housekeeping /Laundry Manager) stated a micro-kill bottle with a green label is available and micro-kill bleach white bottle with light blue label, is available for use. V44 stated he has never seen those bottled solutions and does not have them in V44's housekeeping cart. V44 stated that today (05/06/26) is the first time V44 has heard about and has seen the micro-kill (disinfectant that kills spores with bleach) bottle. Using a sporicidal agent targets spores such as C. diff and prevents the transmission of infections to facility residents, staff, and family members. On 5/6/26 at 10:44am, V60 (Sales Representative) said, This product (Hospital Use Disinfectant-Cleaner 11 disinfectant facility is using to clean resident rooms with C. diff) cannot make the claim that it kills C. diff because the product was never tested on C. diff. This product was specifically tested for the purpose of the things listed on the label and C. diff is not listed on the label. On 5/6/26 at 11:21am, V4 (Infection Preventionist/RN Unit Manager) said, Dirty linen is to bagged. The dirty linen should be bagged and secured to prevent the spread of infection. Wearing PPE in rooms where residents are contact precautions is to protect the resident and the staff. Again, wearing PPE and washing your hands when needed is to prevent the spread of infection. Yes, there are different disinfectant cleaners that kill different bacteria and viruses. If you don't use the cleaner that specifically targets what you're trying to kill, you can spread the infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 05/04/2026 at 11:30 AM, accompanied by V42 (Housekeeping/Laundry Manager), a tour of the facility's laundry room was conducted. Surveyor observed 2 opened bags of soiled linen in the laundry chute, and one soiled blanket with a golf ball sized yellow stain in the dirty laundry receiving bin not in a plastic bag. V42 said, Yeah, those bags (2 opened bags of soiled linen in the laundry chute) are opened up. They (2 opened bags of soiled linen in the laundry chute) popped open on the way down. They (2 opened bags of soiled linen) should be tied shut to prevent spreading germs. On 05/06/2026 at 9:00am, V4 (Infection Preventionist/Unit Manager) stated, I do not order cleaning chemicals for isolation. I am not responsible for that. That's housekeeping R210 is [AGE] years old admitted to the facility on [DATE], medical history includes, but not limited to metabolic encephalopathy, dysphagia oral phase, type 2 diabetes, gastrostomy status, unspecified dementia, essential primary hypertension, etc. On 05/04/2026 10:10AM, R210 observed up in wheelchair, awake and alert with some confusion stated she is doing okay. G- tube pole at bedside, no feeding or water noted to be infusing at this time. R210 was observed wearing a hospital gown, two staff members were in the room and transferred resident back to bed using a mechanical lift. V17 (Restorative Aide) said that resident was on the 4th floor and just transferred to the 3rd floor, not sure the exact date. On 05/05/2026 at 10:20AM, R210 was observed in bed, G-tube feeding infusing at 55ml (milliliters) per hour, an IV pole noted at the bedside. R210 was not on any type of precautions, there was no sign on resident's door or any personal protective equipment (PPE) set up by resident's room. R210 had a PICC line to right arm and was receiving IV antibiotic related to active infection of bacteremia. R210 had pressure ulcer to her coccyx and right lateral foot. On 5/5/2026 at 10:26AM V16 (MDS Coordinator) said that R210 transferred from the 4th floor to the third floor on 05/01/2025, indicating the R210 had been on the third floor for 4 days without being on any type of precaution. Active physician order documented the following: cefazolin Sodium Injection Solution Reconstituted 2 GM (Cefazolin Sodium) Use 2 gram intravenously every 12 hours for bacteremia for 13 Days. Enhanced Barrier Precautions d/t wounds and g tube, order date 4/29/2026. On 5/5/2026 at 10:36AM, V4 (Infection Prevention Nurse) said that she oversees the infection prevention program, but all the managers are supposed to be rounding to make sure that every precaution is in place. Surveyor asked V4 if R210 is supposed to be on any type of precautions. V4 said, She should be on enhanced barrier precaution because she has a G-tube. Surveyor walked with V4 to resident's room where there was no sign of any type of precaution, or an isolation set up. V4 said, I don't know what happened or who transferred resident from the 4th floor, but we will take care of it. Enhanced barrier precaution (EBP) policy revised 1/2026 states in part: General: EBP expands the use of PPE and refers to the use of gowns and gloves during high contact resident care activities that provide opportunities for transfer of MDROs (multi drug resistant organisms) to staff hands and clothing. MDROs and XDROs (extensively drug-resistant organisms) may be indirectly transferred from resident to resident during these high contact care activities. High-contact resident care activities requiring gown and glove use among residents that trigger EBP (continued on next page)

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