

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145718	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2026
NAME OF PROVIDER OR SUPPLIER Thryve of Crestwood		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0677 Level of Harm - Actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to follow policy procedures, failed to provide supervision/touching assistance for eating and/or failed to provide transfer assistance from the bed to wheelchair for four of 42 residents (R6, R14, R37, R131) in the sample reviewed for ADL (Activities of Daily Living) care. These failures resulted in R131's reported discomfort/feelings of uselessness and R37's reported frustration. Findings include: R6's Minimum Data Set (MDS) dated [DATE] includes a Brief Interview for Mental Status (BIMS) of 15 indicating R6 is cognitively intact and indicates that R6 is dependent in chair or bed-to-chair transfers. R6's medical history is significant for end stage renal disease, muscle wasting and atrophy, hemiplegia, dysarthria, unspecified lack of coordination and functional quadriplegia. R37's MDS dated [DATE] has a BIMS of 15 and indicates that R37 is dependent in chair or bed-to-chair transfers. R37's medical history is significant for cardiomegaly, cauda equina syndrome, paraplegia, chronic kidney disease, history of pressure ulcer, peripheral vascular disease, major depressive disorder, bilateral primary osteoarthritis, reduced mobility, obesity, diabetes, neuromuscular dysfunction and polyneuropathy. R131's MDS dated [DATE] has documented a BIMS of 15 and indicates that R131 is dependent in chair or bed-to-chair transfers. R131's medical history is significant for heart failure, muscle wasting and atrophy, peripheral vascular disease and history of acute embolism and thrombosis. R189 has a BIMS of 14 indicating that R189 is cognitively intact dated 5/3/2026. On 5/5/2026 at 8:59 AM R37 stated I need my wheelchair. R37 had a motorized wheelchair that stopped working approximately five years ago and had been using the facility's wheelchair, along with a seat cushion which belonged to R37. R37 reported not being out of bed for about three weeks because the wheelchair is missing. I want to get out of bed. I don't want to get up all the time, but it would be nice to get up when I want to and I can't do that here. On 5/5/2026 at 9:05 AM V35 (Licensed Practical Nurse) stated R37 gets up in the wheelchair with assistance. R37 can propel self once in the wheelchair. V35 was asked when R37 last got up to the wheelchair or whether R37 had refused to get up to the wheelchair. V35 stated staff document any resident activity or refusal in the electronic health record (EHR), in the nursing progress notes or 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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 145718
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F 0677 Level of Harm - Actual harm Residents Affected - Few	care plan. R14's diagnoses include generalized muscle weakness, and lack of coordination. R14's (4/8/26) BIMS (Brief Interview Mental Status) determined a score of 6 (severe impairment). R14's (4/8/26) functional assessment affirms the resident requires supervision or touching assistance for eating and substantial/maximal assistance with lying to sitting on the side of bed. On 5/4/26 at 1:04pm, R14 was lying in bed with the head of bed elevated roughly 45 degrees. R14's lunch was observed on a table adjacent to the bed - not over the bed or within reach. Staff were not present - to provide cues or feeding assistance. R14's meat was not cut into bite size pieces and the meal appeared barely touched. On 5/4/26 at approximately 1:05pm, surveyor inquired if R14 received assistance with eating lunch today R14 stated No. Surveyor inquired if R14 can sit up on the side of the bed without assistance V3 (Assistant Director of Nursing) responded No, he's (R14) able to move the remote. Surveyor inquired what percentage of food R14 ingested V3 replied Maybe about 10%, if that. V3 subsequently left R14's room without placing the meal within reach, elevating the head of bed, or offering feeding assistance. Facility policy titled Residents' Rights for People in Long Term Care Facilities states the facility must care for residents in a manner that promotes your quality of life and must provide services to keep residents' physical and mental health at their highest practical levels. The feeding assistance policy (revised 5/2025) states attempt to provide adequate nutrition to a resident who is unable to feed themselves by hand feeding the resident. Residents who are unable to feed themselves are encouraged, instructed, assisted and/or fed by a qualified staff member. Position resident in proper body alignment for eating. Cut food into small, easily chewable pieces.		

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F 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to post the list of names, addresses (mailing and email), and telephone numbers of the State Survey Agency and failed to post a statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility. This failure affects all 200 residents that reside within the facility. Findings include: Facility census (5/4/2026) documents that 200 residents reside within the facility. R202's face sheet documents in part R202 is a [AGE] year-old resident with diagnoses including: displaced fracture of 3rd metatarsal bone right foot, type 2 diabetes mellitus with diabetic neuropathy, major depressive disorder, wedge compression fracture of 4th vertebrae, unspecified muscle wasting and atrophy, personal history of transient ischemic and dysphagia. R202's minimum data set (4/7/2026) documents in part a brief interview of mental status (BIMS) summary score of 15, indicating R202 is cognitively intact. On 5/4/2026 at 11:35 AM, R202 stated the care here is not good. Not good at all. I'm trying to transfer out of here to another facility. You can complain about things, but nothing changes. I don't think people like to say anything, like they are afraid to talk about it. I don't know where the number to notify you guys (state survey agency) is. I think people have called, but I haven't seen it posted anywhere. On 5/5/2026 at 11:21 AM, V1 (Administrator) stated the state survey agency's contact information was posted in the elevators and on bulletin boards throughout the facility. A facility tour was completed with V1 of all floors, resident units, nurse's stations, bulletin boards, nurse's stations, elevators, reception areas, facility main entrance and did not observe the state survey agency's contact information on any unit or any statement that the resident may file a complaint with the state survey agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility. The elevator bulletin boards were covered in a glass casing to allow access for only staff. V1 confirmed these observations and confirmed that the state survey agency's contact information was not posted within the facility for the residents. V1 did not know why the posting was not posted. V1 stated, I have seen it in the elevators before. I don't know why it's not there. V1 explained the purpose of the posting is to residents can exercise their right to complain about their care to the state survey agency. On 5/5/2026 at 1:53 PM, observed V57 (Receptionist) at the front desk on the computer utilizing a word processing software. Observed V57 fabricating a posting that had the state survey agency's contact information on it. Surveyor inquired what V57 was creating on the computer and V7 stated, You don't see anything and minimized the screen. V57 affirmed V57 was creating a posting that had the state survey agency's contact information on it. On 5/7/2026 at 2:13 PM, V5 (Social Services Director) affirmed residents have the right to complain to the state survey agency about their care. V5 explained there are posters on the floors and in the elevators for the [NAME] retaliation hotline and ombudsman's hotline. V5 affirmed the state survey agency's hotline should be posted with the other postings. V5 recalled seeing the postings last in the elevators in the case within the last few weeks. V5 explained the state survey agency's contact information is important so residents know they can report concerns and complaints to the state survey. Facility policy titled, Required Postings (reviewed 7/2025) documents, It is the policy of the facility to comply with federal regulations in regard to the posting of information for the residents and staff. Other federally required postings such (continued on next page)		

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F 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	as names and telephone numbers of all pertinent state agencies and advocacy groups, such as the state survey agency, the state survey agency, the state licensure office, the office of the state long term care ombudsman program, the protection and advocacy network, home and community based service programs, Medicare and Medicaid contact numbers, grievance procedures and the Medicaid Fraud Control Unit will be posted in a form and manner accessible and understandable to residents and resident representatives .		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to store/label food in accordance with professional standards for food safety, failed to provide a clean, sanitary kitchen environment, food preparation and food storage areas, and failed to follow the facility policies for safe food handling. These failures have the potential to affect all 195 residents that consume nutrition from the kitchen. Findings include: Facility census (5/4/2026) documents 200 residents reside in the facility. Record review of facility enteral feeding list (undated) documents five residents (R15, R69, R70, R157, R210) were on enteral nutrition and did not receive oral nutrition. On 5/04/2026 at 9:07 AM, the initial tour of the kitchen and food service areas was completed. Observed Worcestershire sauce in the cooler with a use-by date 3/6/2026. Observed Chicken salad in a tray, covered in plastic wrap with no date. These findings were confirmed with V7 (Dietary Manager). V7 affirmed the Worcestershire sauce was expired, and the chicken salad should have been dated. V7 removed the Worcestershire sauce from the refrigerator. Observed two visibly dirty scoops covered in a yellowish orange powder, in a plastic bag on a shelf of the dry storage area. No date was on the plastic bag. V7 (Dietary Manager) thought the scoops were used from a chicken [NAME] powder and was unsure when the scoops were last washed or used. V7 removed the scoops from the area. Observed a black dirt like substance caked across the floor of the dry storage room tiles across approximately 25% of the tiles. V7 confirmed the observation and stated that's how the floor is. They mop it every day and haven't mopped it yet. Surveyor wiped the black substance on the floor with a paper towel and the black substance transferred to the paper towel. V7 stated, it (the dry storage floors) doesn't look clean. On 05/04/2026 9:21 AM, observed black and reddish/brown stains the covered over 75% of the ceiling near the oven, range, and food prep areas. Observed old grease covered approximately 75% of the window of the oven, which was in use to cook meat, and dark brown grease/food particulate covering approximately 25% of the dials to operate the oven. Observed tan food particulate splattered across approximately 25% of the stainless-steel food storage area, black/tan dried food debris on the ceiling above the food prep area, and crumbs/dirt throughout the floor of the food prep area. These observations were confirmed with V31 (Cook). V31 stated, I don't know what those stains are on the ceiling. I think it is grease. V31 explained that the dried food particulate splatters were from the use of the food processors to make pureed food. V7 observed the ceiling and stated the stains were from grease/dirt and V7 had been asking the administration for the ceiling to be replaced for a long time. V7 confirmed the ceiling had been like that since before V7 had started as the dietary manager over a year ago. Observed plastic food bins of dried mashed potato flakes and powered thickener. The lids to both bins had a gray/black dirt like substance on them, and bits of dried shredded orange cheese. The dry mashed potato flakes bin had a sticker indicating a date of 2/2 and a use by date of 60 days. V7 confirmed these observations and affirmed the masked potato flake bin was mislabeled and stated, That date on there is wrong, they are good for a year. V7 described the lids as having dried grit and (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	removed the lids to be cleaned. On 5/4/2026 at 10:21 AM, observed black and reddish/brown stains the covered over 75% of the ceiling near the oven, range, and food prep areas. Observed old grease covered approximately 75% of the window of the oven, which was in use to cook meat, and dark brown grease/food particulate covering approximately 25% of the dials to operate the oven. These findings were observed and confirmed with V8. V8 explained the stains were from dirt and grease. V8 affirmed the exhaust hood wasn't functioning properly and they had a vendor come and assess it. The vendor believed the exhaust ventilation system was not pulling enough air. V8 explained the reason why the oven had grease was the grease was located between two panes of glass, and there was no way to clean the glass. V8 explained dirt and grease on the ceiling of the kitchen can cause an unsanitary environment and increases the risk for a fire hazard. Observed the dry storage room with V8. The drywall/paint appeared brown and streaked, and the paint appeared to be falling from the wall. An approximately 12 inch by 6-inch portion of the wall did not have paint and left the base of the wall exposed. The tiles of the corner of the dry storage area were broken or absent, exposing black adhesive/underlayment. These observations were confirmed with V8. V8 explained the facility's pipe leak had caused water damage in the dry storage area. A plumber repaired the pipe, but the other broken areas of the dry storage room had not been repaired yet. Observed a black, spotted substance on the tiles of the dry storage room. This finding was confirmed with V8. V8 stated, it looks to me like it is black mold. The U.S. Food and Drug Administration (FDA) food code documents, .4-301.14 Ventilation Hood Systems, Adequacy. Ventilation hood systems and devices shall be sufficient in number and capacity to prevent grease or condensation from collecting on walls and ceilings . 6-304 Ventilation6-304.11 Mechanical. If necessary to keep rooms free of excessive heat, steam, condensation, vapors, obnoxious odors, smoke, and fumes, mechanical ventilation of sufficient capacity shall be provided . 4-204.11 Ventilation Hood Systems, Drip Prevention. The dripping of grease or condensation onto food constitutes adulteration and may involve contamination of the food with pathogenic organisms. Equipment, utensils, linens, and single service and single use articles that are subjected to such drippage are no longer clean . 4-301.14 Ventilation Hood Systems, Adequacy. If a ventilation system is inadequate, grease and condensate may build up on the floors, walls and ceilings of the food establishment, causing an insanitary condition and possible deterioration of the surfaces of walls and ceilings. The accumulation of grease and condensate may contaminate food and food-contact surfaces as well as present a possible fire hazard .4-602.13 Nonfood-Contact Surfaces. The presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food. If these areas are not kept clean, they may also provide harborage for insects, rodents, and other pests . 6-201.18 Walls and Ceilings, Studs, Joists, and Rafters. Walls and ceilings that are of smooth construction, nonabsorbent, and in good repair can be easily and effectively cleaned. Special requirements related to the attachment of accessories and exposure of wall and ceiling studs, joists, and rafters are intended to ensure the cleanability of these surfaces . Facility policy titled Residents' Rights for People in Long Term Care Facilities states the facility must be safe and clean. Facility policy titled Safe Food Handling Practices states all food must be purchased, stored, (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	prepared and distributed in a clean, safe and sanitary manner. The purpose is to minimize contamination and bacteria.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview and record review, the facility failed to contain garbage/refuse within dumpsters and failed to maintain garbage storage areas in a sanitary condition. These failures affected all 200 residents that reside within the facility. Findings include: Facility census (5/4/2026) documents 200 residents reside in the facility. On 5/4/2026 at 1:36 PM, observed the garbage area and staff smoking area with V42 (Housekeeping/Laundry Manager). Outside of the dumpsters near the garbage area were food wrappers, loose medical waste including soiled gloves, flattened rotting cardboard, and cigarette butts. In the garbage area was over 6 pallets of wood, rotting pieces of wood stacked against the fence used, used milk crates on the ground, food wrappers/waste, broken medical equipment/beds, large spools of light blue fabric, large pieces of the fabric in piles on the ground, soiled plastic garbage bags, piles of used siding, piles of used PVC piping, rotting cardboard pieces and boxes, used plastic bags, and other unidentifiable garbage. V42 observed these areas and confirmed the observations. V42 affirmed the garbage was not contained and stated, Some of that stuff (garbage) is from last week. Some of it has been here for years. All of it needs to be cleaned out. I suggested we rent a dumpster a few weeks ago and get all of it cleaned out, it just hasn't happened yet. V42 explained the garbage not being contained creates an unsanitary environment and can become a pest control issue as the garbage can feed or harbor pests. Observed the smoking area with V48. The smoking receptacle attached to the building was completely full of cigarettes. Cigarette butts littered the back parking lot and staff smoking area. Observed a pail in the staff smoking area that had cigarette butts and discarded paper products including crumpled paper and paper straw wrappers. No sand was observed in the pail. V42 confirmed these observations. V42 affirmed it was V42's responsibility to remove the cigarette butts. V42 explained placing the used cigarettes in the pail with paper products could create a fire hazard. Facility policy titled Disposal of Garbage and Refuse (reviewed 5/2025) documents, The facility will dispose of garbage and refuse properly and in a timely manner. All garbage and refuse container will be maintained properly and in a timely manner. 1. The facility will assure all waste is properly contained in dumpster or compactors with lids and covered. 3. Garbage storage areas are maintained in a sanitary condition to prevent the harborage and feeding of pests and rodents.		

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NAME OF PROVIDER OR SUPPLIER Thryve of Crestwood		STREET ADDRESS, CITY, STATE, ZIP CODE 14255 South Cicero Avenue Crestwood, IL 60445	
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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and record review, the facility failed to develop a facility assessment that a) accurately identified the capacity for residents b) identified ethnic, cultural or religious factors that potentially affected the care provided by the facility c) identified in-house dialysis unit services provided to the facility's residents d) accurately identified the staffing plan for direct care staff e) a recruitment and retention program plan for maximizing recruitment and retention of direct care staff. These failures affected all 200 residents that reside in the facility. Findings include: Facility census (5/4/2026) document 200 residents reside in the facility. Facility assessment (reviewed 3/2026) documents the following: 1) the facility's capacity for residents is 182 residents. 2) There is no ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. 3) the facility's dialysis unit is not identified in the facility assessment 4) 24 licensed nurses per day, 40 nursing aides per day, 1 dietician or qualified dietary manager per day, 5) 1:27 licensed nurse ratio in the post-acute care unit all shifts (1 RN, 1 LPN), 1:30 Licensed nurse ratio all units all shifts in long term care units (1 RN, 1 LPN). 6) Nurse's aides staffing ratio 1:13 on days/evenings, 1:18 ratio on nights on post-acute care units. 7) Nurse's aides staffing ratio 1:13 on days/evenings, 1:19 ratio on nights on post-acute care units. 8) There is no indication of a recruitment/retention plan for maximizing recruitment and retention of direct care staff. On 5/5/2026 at 1:48 PM, V1 (Administrator) affirmed V1 was involved in the completion of the facility assessment. V1 reviewed the facility assessment and affirmed the facility's capacity to care for residents was over 250 residents, not 182. V1 affirmed that the cultural needs of the facility's residents were not identified. V1 explained the facility does have residents of Latin descent, that are African American, Christian, and of Polish decent. V1 explained the facility does provide services to meet their needs such as Cinco de Mayo parties and in-house church services. V1 reviewed the staffing plan and affirmed the staffing plan was incorrect. V1 affirmed the purpose of the facility assessment is to identify the resources needed to care for the residents. On 5/6/2026 at 11:30 PM, V55 (Chief Operating Officer) affirmed V55, V56 (Chief Clinical Officer) and V50 (Vice President of Clinical Operations) serve as the governing body for the facility. V55 affirmed the governing body is responsible for the development and implementation of policies in the facility. V55 explained the facility had recently undergone a change of ownership on 3/1/2026 and the new governing body started overseeing on 3/1/2026. V55 affirmed V55 was involved in the revision of the facility assessment when the new governing body assumed the facility. V55 reviewed the facility assessment. V55 affirmed that the facility's capacity is incorrect and is not 182. V55 confirmed that the ethnic makeup and services provided to meet the residents ethnic, cultural and religious factors were not identified. V55 recalled that there were Spanish speaking residents, polish speaking residents, Christian residents. V55 confirmed the facility does not have a dietician/dietary manager one per day as indicated in the facility assessment. V55 confirmed the staffing ratio in the facility assessment was incorrect. V55 stated the staffing ratio should be 1:20 for licensed nurses and that the facility is staffing licensed nurses 2nd floor: 2 on AM shift, 2 on PM shift, and 2 on night shift. 3rd Floor: 3 on AM shift, 2 on PM shift, 2 on night shift, 4th floor 3 on AM shift, 2 on PM, and 2 on night shift. V55 affirmed there should be 15 CNAs per shift. V55 and V56 reviewed the facility assessment and confirmed the facility assessment does not address the in-house dialysis unit. V55 affirmed that the facility has a recruitment and retention program including a corporate recruiter, ad postings on job (continued on next page)		

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	board websites, soliciting schools, and have a monthly allowance to build staff culture. V55 reviewed the facility assessment and affirmed the recruitment and retention plan is not identified in the facility assessment. Facility assessment policy (1/2026) documents in part, This facility conducts and documents a facility-wide assessment to determine what resources are necessary to care for our residents competently during both day-to-day operations (including nights and weekends) and emergencies. The purpose of this policy is to establish responsibilities and procedures for the facility assessment process. 1. The facility assessment will, at a minimum, address or include: a. The facility's resident population, including but not limited to: i. Number of residents and the facility's capacity; ii. The care required by the resident population, using evidence-based, data-driven methods that consider the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments; iii. The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; iv. The physical environment, equipment, services and other physical plant considerations that are necessary to care for this population; and v. Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. b. The facility's resources, including but not limited to: i. All buildings and/or other physical structures and vehicles; ii. Equipment (medical and non-medical); iii. Services provided, such as physical therapy, pharmacy, behavioral health and specific rehabilitation therapies; iv. All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; v. Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and vi. Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. c. A facility-based and community-based risk assessment, utilizing an all-hazards approach. 2. In conducting the facility assessment, the facility will ensure: a. Active involvement of the following participants in the process: i. Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and ii. Direct care staff, including but not limited to RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. iii. The facility must also solicit and consider input received from residents, resident representatives, and family members. iv. The environmental operations manager, and other department heads (e.g., dietary manager, director of rehabilitation services, or other individuals) should be involved as needed. 3. The facility will use the facility assessment to: a. Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care. b. Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. c. Consider specific staffing needs for each shift, such as day, evening, night and adjust as necessary based on any changes to its resident population. d. Develop and maintain a plan to maximize recruitment and retention of direct care staff. e. Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care.		

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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, 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 (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 use include: Dressing Bathing/showering Transferring Providing hygiene Changing linens Changing briefs or assisting with toileting Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator Wound care Record review of Hospital Use Disinfectant-Cleaner 11 label documents, in part, Effective against Escherichia coli, Listeria monocytogenes, Pseudomonas aeruginosa, Staphylococcus aureus (MRSA), Staphylococcus aureus (CA-MRSA), Salmonella typhi, Norovirus, Influenza A (H1N1), Influenza A (H3N2), HIV-1, Hepatitis B Virus (HBV), Hepatitis C Virus (HCV), SARS-CoV-2, Vaccinia Virus and other listed bacteria and viruses when used as directed. Treated surfaces must remain wet for 10 minutes. C. diff is not listed. Record review of the facility's housekeeping policy/guidelines dated 05/2026 documents in part To provide guidelines to maintain a safe and sanitary environment for residents, facility staff, and visitors. Record review of facility policy titled, Infection Control and Control Plan-General, dated 1/2026, documents, in part, (Facility) is committed to ensuring that all appropriate infection and control measures are in place as to be determined by State and Federal Regulations as well as CDC recommendations and guidance. The facility will have an Infection Preventionist to assist and oversee the infection control program. The facility shall comply with recommendations provided by IDPH or certified local health department, including, but not limited to, testing plans, infection control assessments, training, or other measures designed to reduce infection rates and disease outbreaks. Review of the facility's Housekeeping policy for linens section 1.f dated 01/02/2026 documents in part Environmental services staff shall not handle soiled linens unless it is properly bagged. Record review of Pamphlet titled, Illinois Long-Term Care Ombudsman Program Residents' Rights for (continued on next page)		

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	People in Long-Term Care Facilities, revised date 11/18, documents, in part, Your facility must be safe, clean, comfortable and homelike.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview and record review, the facility failed to follow their preventative maintenance policy, failed to maintain and provide preventative maintenance to ensure the environment was safe, functional, sanitary, and comfortable for residents and staff; failed to complete needed repairs to the environment; failed to ensure resident shower rooms were in good repair and had methods for enhancing privacy (curtains) for public shower rooms. These failures affect the 54 residents on the second floor that utilize the shower rooms and have the potential to affect all 200 residents that reside in the facility. Findings include: Facility census (5/4/2026) documents 54 residents reside on the 2nd floor, and 200 residents reside in the facility. On 5/4/2026 at 10:21 AM, observed three broken light fixtures in the kitchen with no lightbulbs. Three light covers (diffusers) were observed with cracks in the cover, and three other lights were observed without any cover, leaving exposed lightbulbs. These observations were confirmed with V8, Maintenance Director. V8 stated the purpose of the cover is to protect the bulbs and protect staff as the lightbulb can explode. Observed the ceiling above the clean dishware/pots/pans. The ceiling tile was discolored and largely bowed downward in the middle of the tile, causing the insulation above the tile to be exposed. This observation was confirmed with V8. V8 explained the ceiling tiles were fireproof and the material exposed out from the tile was insulation from the fireproofing. V8 explained there was a pipe that was leaking last month and believed the cause of the ceiling tiles being bowed was from water damage. V8 recalled the tile order was placed last week but did not know when the tiles would arrive. In the dry storage area, observed drywall peeling approximately 12 inches, with paint chips/debris on the ground. The drywall/paint appeared brown and streaked, and the paint appeared to be falling from the wall. An approximately 12 inch by 6-inch portion of the wall did not have paint and left the base of the wall exposed. The tiles of the corner of the dry storage area were broken or absent, exposing black adhesive/underlayment. These observations were confirmed with V8. V8 explained the facility's pipe leak had caused water damage in the dry storage area. A plumber repaired the pipe, but the other broken areas of the dry storage room had not been repaired yet. On 5/4/2026 at 12:24 PM, observed the 2nd floor shower rooms with V2 (Director of Nursing) and V8 (Maintenance Director). The shower rooms felt warm and humid. Observed linen on the ground on the shower room. V2 stated the linen was from a resident who had just taken a shower. Observed the shower area and a puddle of water was on the ground underneath the shower chair of the shower area. Observed a missing ceiling tile above the shower area with a rusted, exposed pipe. The pipe was wet and leaking with approximately 1 drop of water every 8-10 seconds that landed on the shower chair within the shower area (where the resident had been showering). These observations were confirmed with V2 and V8. V8 explained V8 was aware of the leak and that the pipe had rusted out to the point of water leaking. A plumbing contractor had been out to assess the leak but V8 was unsure if any quote was approved or when the pipe would be fixed. Surveyor flipped the light switch next to the unused shower stall, and nothing happened. V8 stated that goes to the exhaust fan. It doesn't work. There were no curtains or other privacy barriers in the shower area or within the shower room. This observation was confirmed with V2 and V8. On 5/6/2026 at 4:55 PM, requested any maintenance orders in TELS or records regarding the disrepair items in the facility. V8 searched through V8's phone and could not produce any documentation. V1 (Administrator) and V8 could not produce any work orders/documentation related to the items in disrepair. No further documentation was provided prior to the exit of the facility. V1 affirmed that ceiling tiles for the kitchen were on order to replace the ceiling tiles in the kitchen but (continued on next page)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	would not be in until 5/16/2026. Facility preventative maintenance policy documents, A Preventative Maintenance Program shall be developed and implemented to ensure the provision of a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.1. The Maintenance Director is responsible for developing and maintaining a schedule of maintenance services to ensure that the buildings, grounds, and equipment are maintained in a safe and operable manner. 2. The Maintenance Director shall assess all aspects of the physical plant to determine if Preventative Maintenance (PM) is required. Required PM may be determined from manufacturer's recommendations, maintenance requests, grand rounds, life safety requirements, or experience. 3. If preventative maintenance is required, the Maintenance Director shall decide what tasks need to be completed and how often to complete them. 4. The Maintenance Director shall utilize the TELS calendar and scheduled prompts to assist with keeping track of all tasks and work orders . The U.S. Food and Drug Administration (FDA) food code (2022) documents, 6-201.18 Walls and Ceilings, Studs, Joists, and Rafters. Walls and ceilings that are of smooth construction, nonabsorbent, and in good repair can be easily and effectively cleaned. Special requirements related to the attachment of accessories and exposure of wall and ceiling studs, joists, and rafters are intended to ensure the cleanability of these surfaces. 6-202.11 Light Bulbs, Protective Shielding. Shielding of light bulbs helps prevent breakage. Light bulbs that are shielded, coated, or otherwise shatter-resistant are necessary to protect exposed food, clean equipment, utensils and linens, and unwrapped single-service and single-use articles from glass fragments should the bulb break .		

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have enough outside ventilation via a window or mechanical ventilation, or both. Based on observation, interview and record review, the facility failed to ensure adequate ventilation were in good working condition in the kitchen and the second-floor shower room. These failures caused excess grease and dirt to accumulate on the ceiling of the kitchen, which increased the risk of food contamination and created a potential fire hazard. These failures affected 54 residents that reside on the second floor and has the potential to affect all 195 residents that consume nutrition from the kitchen. Findings include: Facility census (5/4/2026) documents 200 residents reside in the facility. Record review of facility enteral feeding list (undated) documents five residents (R15, R69, R70, R157, R210) were on enteral nutrition and did not receive oral nutrition. On 05/04/2026 9:21 AM, observed black and reddish/brown stains the covered over 75% of the ceiling near the oven, range, and food prep areas. Observed old grease covered approximately 75% of the window of the oven, which was in use to cook meat, and dark brown grease/food particulate covering approximately 25% of the dials to operate the oven. V7 (Dietary manager) observed the ceiling and stated the stains were from grease/dirt and V7 had been asking the administration for the ceiling to be replaced for a long time. V7 confirmed the ceiling had been like that since before V7 had started as the dietary manager over a year ago. The hood did not appear to be functioning, and no sounds could be heard indicating the hood was on. No air could be felt moving upwards. V7 confirmed the hood was not on and told another staff member to turn on the exhaust hood. On 5/4/2026 at 10:21 AM, observed black and reddish/brown stains the covered over 75% of the ceiling near the oven, range, and food prep areas. Observed old grease covered approximately 75% of the window of the oven, which was in use to cook meat, and dark brown grease/food particulate covering approximately 25% of the dials to operate the oven. These findings were observed and confirmed with V8. V8 explained the stains were from dirt and grease. V8 affirmed the exhaust hood wasn't functioning properly and they had a vendor come and assess it. The vendor believed the exhaust ventilation system was not pulling enough air. V8 explained dirt and grease on the ceiling of the kitchen can cause an unsanitary environment and increases the risk for a fire hazard. On 5/4/2026 at 12:24 PM, observed the 2nd floor shower rooms with V2 (Director of Nursing) and V8 (Maintenance Director). The shower rooms felt warm and humid. Observed linen on the ground on the shower room. V2 stated the linen was from a resident who had just taken a shower. Observed the shower area and a puddle of water was on the ground underneath the shower chair of the shower area. Surveyor flipped the light switch next to the unused shower stall, and nothing happened. V8 stated that goes to the exhaust fan. It doesn't work. Both exhaust fan covers were covered in a thick layer of dust. V8 confirmed this observation. On 5/6/2026 at 4:55 PM, requested any maintenance orders in TELS or records regarding the disrepair items in the facility. V8 searched through V8's phone and could not produce any documentation. V1 (Administrator) and V8 could not produce any work orders/documentation related to the ventilation in disrepair. No further documentation was provided prior to the exit of the facility. V1 stated a vendor had come and assessed the exhaust van and that the ventilation system needed to be replaced. Facility preventative maintenance policy documents, A Preventative Maintenance Program shall be developed and implemented to ensure the provision of a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. 1. The Maintenance Director is responsible for developing and maintaining a schedule of maintenance services to ensure that the buildings, grounds, and equipment are maintained in a safe and operable manner. 2. The Maintenance Director shall assess all aspects of the physical plant to determine if Preventative Maintenance (PM) is required. Required PM may be determined from manufacturer's recommendations, maintenance requests, grand rounds, life safety (continued on next page)		

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	requirements, or experience. 3. If preventative maintenance is required, the Maintenance Director shall decide what tasks need to be completed and how often to complete them. 4. The Maintenance Director shall utilize the TELS calendar and scheduled prompts to assist with keeping track of all tasks and work orders . The U.S. Food and Drug Administration (FDA) food code documents, .4-301.14 Ventilation Hood Systems, Adequacy. Ventilation hood systems and devices shall be sufficient in number and capacity to prevent grease or condensation from collecting on walls and ceilings . 6-304 Ventilation6-304.11 Mechanical. If necessary to keep rooms free of excessive heat, steam, condensation, vapors, obnoxious odors, smoke, and fumes, mechanical ventilation of sufficient capacity shall be provided . 4-204.11 Ventilation Hood Systems, Drip Prevention. The dripping of grease or condensation onto food constitutes adulteration and may involve contamination of the food with pathogenic organisms. Equipment, utensils, linens, and single service and single use articles that are subjected to such drippage are no longer clean . 4-301.14 Ventilation Hood Systems, Adequacy. If a ventilation system is inadequate, grease and condensate may build up on the floors, walls and ceilings of the food establishment, causing an insanitary condition and possible deterioration of the surfaces of walls and ceilings. The accumulation of grease and condensate may contaminate food and food-contact surfaces as well as present a possible fire hazard .		

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, the facility failed to develop a smoking policy that meets state law requirements for the Smoke Free Illinois Act, failed to develop a resident smoking policy that includes use of e-cigarettes (vapes), and failed to implement/follow the staff smoking policy within the employee handbook. This failure affected all 45 residents that smoke in the facility and has the potential to affect all 200 residents that reside in the facility. Findings include: Facility census (5/4/2026) documents 200 residents reside in the facility. Facility smoking list (undated) documents 45 residents smoke in the facility. Record review of document titled THRYVE OF CRESTWOOD GARDEN PATIO documents the patio will be closed during mealtimes and after hours. The patio may also be closed due to inclement weather or any emergent situation and lists the smoking times. There is no instruction that residents cannot smoke within 15 feet of the entrance to the smoking patio. Record review of (410 ILCS 82/) Smoke Free Illinois Act (enacted 1/1/2028, revised 1/1/2024) documents in part, .Smoking in public places, places of employment, and governmental vehicles prohibited. No person shall smoke in a public place or in any place of employment or within 15 feet of any entrance to a public place or place of employment .On 5/4/2026 at 1:01 PM, observed R68 smoking less than 15 feet from the entrance to the smoking area (garden patio) near the handicap door access button. Observed V53 assisting other residents with smoking in the smoking area. V53 (Activity Aide) observed R68 smoking less than 15 feet from the entrance and confirmed the distance was less than 15 feet. V53 affirmed V53 was the staff member responsible for supervising the smoking area during the observation. V53 affirmed R68 should not be smoking that close to the door, and instructed R68 to go further into the smoking area to smoke away from the door. On 5/4/2026 at 1:17 PM, measured the distance from the threshold of the door to where R68 was observed smoking using a measuring tape. The distance was 91 inches (approximately 7.8 feet). This observation was confirmed with V53 and V53 confirmed R68 was smoking less than 15 feet from the threshold of the door. On 5/4/2026 at 1:36 PM, observed the garbage area and staff smoking area with V42 (Housekeeping/Laundry Manager). Outside of the dumpsters near the garbage area were food wrappers, loose medical waste including soiled gloves, flattened rotting cardboard, and cigarette butts. Observed the smoking area with V48. The smoking receptacle attached to the building was completely full of cigarettes. Cigarette butts littered the back parking lot and staff smoking area. Observed a pail in the staff smoking area that had cigarette butts and discarded paper products including crumpled paper and paper straw wrappers. No sand was observed in the pail. V42 confirmed these observations. V42 affirmed it was V42's responsibility to remove the cigarette butts. V42 explained placing the used cigarettes in the pail with paper products could create a fire hazard. V42 affirmed staff should be using the appropriate receptacles for discarding used cigarettes. On 5/6/2026 at 2:13 PM, V5 (Social Services Director) affirmed V5 is responsible for assessing smoking ability for the residents in the facility. V5 affirmed that R68 is safe to smoke. V5 explained that residents should not be smoking within 15 feet of the door in the smoking area. On 5/6/2026 at 4:50 PM, V1 (Administrator) affirmed residents should be smoking at least 15 feet away from the facility. V1 affirmed residents do use electronic cigarettes (vapes). V1 reviewed the resident smoking policy and the staff smoking expectations in the staff handbook. V1 affirmed the resident smoking policy does not address smoking within 15 feet of an entrance to the facility and does not identify resident e-cigarette use in the facility. No other policies were presented to the survey team prior to the exit of the survey that identify resident e-cigarette use or the requirement that residents must smoke 15 feet (continued on next page)		

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	from an entrance to the facility. Facility policy titled Resident Smoking (Revised November 2013) documents, PURPOSE: To establish guidelines to prohibit smoking by residents and visitors in the building except in designated areas. To establish guidelines for the specific circumstances in which residents may smoke in the designated areas and when increased supervision is required. Policy Specifications: 1. All residents who desire to smoke will be assessed by the Interdisciplinary Team to determine if the individual is appropriate for independent smoking. 2. If assessed to be appropriate for independent smoking, the resident must sign a Smoking Contract with the facility. 3. Only those residents assessed to be appropriate for independent smoking and who have executed a Safe Smoking Contract with the facility may smoke in the designated areas. 4. Some residents may require more intensive staff supervision while smoking. These residents smoke separately from other residents, under the supervision of a staff member specifically designated to assist them. Behaviors that may trigger additional resident supervision while smoking include, but are not limited to: a. Being unable to state facility smoking rules b. Being unable to follow facility smoking rules without prompts c. Using smoking materials in an inappropriate manner d. Giving or selling cigarettes and/or smoking materials to other residents e. Collecting or attempting to use discarded smoking materials f. Asking for smoking materials from other residents g. Attempting to take other residents' smoking materials h. Attempting to intimidate another resident for the purpose of taking cigarettes or smoking materials 5. Smoking by residents and their visitors is permitted only in designated areas. 6. Possessing, carrying, or holding materials used to light cigarettes, cigars (including but not limited to lighters, torches, etc.) by residents is prohibited inside the building. Residents must give smoking lighting materials to staff when they enter the building, even if the resident has been assessed to be independent in carrying such materials when off the premises. 7. Persons bringing smoking materials into the facility for residents' use must leave these items at the front desk. Smoking materials left for an individual resident will be labeled and forwarded to an assigned staff member who will ensure they are available to the resident for whom the materials have been labeled. 8. Residents are prohibited from giving smoking materials to other residents. 9. Residents are prohibited from asking other residents for smoking materials. The policy does not address resident use of e-cigarettes/vapes and does not address the state requirement that prohibits smoking 15 feet from any entrance. Facility smoking policy and smoking contract (revised 1/2026) does not indicate where the smoking area of the facility is, or that residents should not be smoking within 15 feet of the entrance to the facility in the smoking area. Vaping or other e-cigarette use is not addressed in this policy. The facility's employee handbook (undated) documents This Smoke Free Policy includes the use of electronic nicotine delivery systems - known as e-cigarettes, e-cigars, e-hookahs and e-pipes. To protect and enhance indoor air quality and contribute to the health and well-being of all employees and visitors, [NAME] HEALTHCARE shall be entirely smoke free and vape free. [NAME] Healthcare is committed to providing a smoke and vape free environment. Smoking and vaping is not permitted inside the facility at any time. Smoking and vaping is only permitted outside the facility in designated areas where smokers will not interfere with those entering and leaving the facility. All cigarette butts and wrappers must be deposited in waste containers. Smokers are not entitled to special smoking breaks and smoking will be permitted only during break or lunch periods. Cigarette butts and other waste must be disposed of properly.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to follow policy procedure, failed to ensure that call lights were within reach, and failed to ensure that call lights were functioning for four of 42 dependent residents (R11, R14, R27, R84) in the sample reviewed for accommodation of needs. Findings include: R27's face sheet documents diagnoses that include but are not limited to acquired absence of right ankle, type 2 diabetes, necrotizing fasciitis, pneumonia, and renal dialysis. R27's BIMS (brief interview for mental status) score, dated 5/04/26, is 12 which indicates R27's cognition is moderately impaired. On 5/4/26 at 10:00am, R27 was observed laying on her back and said, Can you move my table closer to me? Surveyor asked, Where is your call light? R27 replied, I don't know, can you just move my table closer to me? I'd do it myself, but I can't. Surveyor observed R27's call light behind R27's bed not within reach. R27's care plan, dated 4/28/26, documents, in part, Falls: (R27) is at risk for Falls r/t (related to) acquired absence of right ankle, with interventions that documents, in part, promote placement of call light within reach. On 5/4/26 at 10:02am, V11 (Wound Care Nurse/LPN/Licensed Practical Nurse) said, Geez. We (staff) just provided care to her (R27) a few minutes ago. Yes, it's (R27's call light) behind her (R27) bed. No, it's (R27's call light) not within reach. On 5/06/25 at 4:45pm, V2 (Director of Nursing/DON) said, Our (facility) expectation is that the call lights should be within reach so we (facility staff) can address the residents' needs. R11's diagnoses include hemiplegia and hemiparesis. R11's (2/26/26) BIMS (Brief Interview Mental Status) determined a score of 15. R11's (2/26/26) functional assessment affirms resident requires partial/moderate assistance with chair/bed to chair transfer. R11's (3/8/24) care plan includes ADL (Activities of Daily Living) self-care performance deficit related to hemiplegia, interventions: encourage resident to use call bell for assistance. On 5/4/26 at 10:23am, R11 was observed sitting on the bed, however the call light was on the dresser - out of reach. Upon further inspection the call light was also noted to be unplugged. On 5/4/26 at 10:30am, surveyor inquired about concerns with R11's call light V14 (LPN/Licensed (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Practical Nurse) entered the room and stated It's not plugged up, your call light don't work? R11 responded I (R11) don't think so, I'm not sure. Surveyor inquired if R11's call light was plugged into the wall V14 replied It's not plugged in. — R14's diagnoses include lack of coordination, history of falling, and repeated falls. R14's (4/8/26) BIMS determined a score of 6 (severe impairment). R14's (4/8/26) functional assessment affirms resident required substantial/maximal assistance to roll left and right. R14's (10/21/24) care plan states encourage the resident to use call bell for assistance. On 5/4/26 at 10:51am, R14's call light was dangling from the side rail below the mattress - out of reach. V13 (LPN) entered the room to inspect R14's indwelling urinary catheter (as requested) however left the room without placing R14's call light within reach. Surveyor inquired if R14 was able to reach the call light R14 nodded his head no. — R84's diagnoses include cerebral infarction and cognitive communication deficit. R84's (1/28/26) BIMS determined a score of 13 (cognition intact). R84's (1/28/26) functional assessment affirms resident requires partial/moderate assistance with chair/bed to chair transfer. R84's (1/7/25) care plan states encourage the resident to use bell to call for assistance. On 5/4/26 at 11:02am, R84's call light was observed on the floor and was not plugged into the wall. Surveyor inquired about concerns with R84's call light V15 (LPN) entered the room and stated This here is the call light and there's nothing plugged in. It's a cord down here on the floor that appears to be it. The call light response policy (reviewed 5/1/25) states ensure the call light is always within the resident's reach. When the patient or resident is in bed or confined to a bed or chair, provide the call light within easy reach of the patient or resident. Report all defective call lights to the nurse supervisor or maintenance director promptly. Record review of pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, in part, 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. Your facility must be safe, clean, comfortable, and homelike. You (continued on next page)		

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review the facility failed to follow policy procedures, failed to ensure that staff identify/address housekeeping/maintenance concerns, and/or failed to repair broken equipment for nine of 42 residents (R1, R7, R8, R15, R23, R27, R91, R99, R110) in the sample reviewed for safe/clean/comfortable/homelike environment. Findings include: R15's face sheet documents diagnoses that include but are not limited to dementia, type 2 diabetes, and metabolic encephalopathy. R15's MDS (Minimum Data Set), Section C, dated 2/25/26, documents, in part, that R15 is rarely understood and that R15's Cognitive Skills for Daily Decision Making is Severely Impaired. R15 unable to be interviewed due to altered mental status. On 5/04/26 at 9:55am, surveyor attempted to read R15's tube feeding bottle; however, the room was very dark. There were no ceiling lights observed in R15's room. Surveyor observed a fluorescent tube light attached to the wall behind R15's bed. Surveyor asked V9 (Certified Nursing Assistant/CNA) if V9 could turn the light on. V9 replied, The lights behind the residents' (R15, R23, R27) beds in this room do not work. They (lights) haven't worked for some time. I'm not sure how long they (lights) haven't worked. There's only that light. V9 pointed to one fluorescent light on the wall, in the middle of the room, across from R15, R23, and R27's beds). V9 said, Yes, it a little difficult to see, but we (staff) use that one light and the lights coming from the outside through the windows. R27's face sheet documents diagnoses that include but are not limited to type 2 diabetes, necrotizing fasciitis, acquired absence of right ankle, pneumonia, and renal dialysis. R27's BIMS (brief interview for mental status) score, dated 5/04/26, is 12 which indicates R27's cognition is moderately impaired. On 5/4/26 at 10:00am, R27 said, Yeah, there need to be more light in here. It's nighttime all day. Can you move my table closer to me? R23's face sheet documents diagnoses that include but are not limited to type 2 diabetes, dementia, and opioid abuse. R23's BIMS (brief interview for mental status) score, dated 2/13/26, is 15 which indicates R23 is cognitively intact. On 5/4/26 at 10:17am, R23 said, Well, I'm by the window, so I get more light than them (R23's roommates). I don't know. I don't wanna complain. I'm sure they'll (facility staff) will get us more lighting. R7's face sheet documents diagnoses that include but are not limited to type 2 diabetes, depression, (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and seizures. R7's BIMS (brief interview for mental status) score, dated 5/01/26, is 15 which indicates R7 is cognitively intact. On 5/4/26 at 10:25am, surveyor observed no overhead light in R7's room. Surveyor observed a table lamp next to R7's bed on R7's dresser. R7 said, The light in this lamp don't work. See. R7 attempted to turn on R7's lamp, but R7's lamp would not turn on. R7 said, This lightbulb has been out for days. Yeah, they (facility staff) know about it. They (facility staff) keep saying they (facility staff) gonna change but never do. Of course, I need more light in here. It's (inadequate lighting) depressing. R110's face sheet documents diagnoses that include but are not limited to chronic obstructive pulmonary disease, type 2 diabetes, hypoxemia, and depression. R110's BIMS (brief interview for mental status) score, dated 3/20//26, is 13 which indicates R110 is cognitively intact. On 5/4/26 at 10:28am, surveyor observed no overhead light nor a bedside lamp in R110's room. R110 said, The staff complain about how dark it is all the time. It's (lighting) better during the day, but once it gets dark out, you can't see sh** up in here. I be bumping into everything. On 5/4/26 at 10:30am, surveyor observed a damaged metal faucet with frayed, sharp edges in the shared bathroom for R8, R91, and R99. While attempting to turn the faucet handle, surveyor experienced discomfort due to the exposed sharp metal edges. R8's face sheet documents diagnoses that include but are not limited to chronic obstructive pulmonary disease, depression, and acquired absence of right leg. R8's BIMS (brief interview for mental status) score, dated 4/24/26, is 15 which indicates R8 is cognitively intact. R91's face sheet documents diagnoses that include but are not limited to prediabetes, weakness, and seizures. R91's BIMS (brief interview for mental status) score, dated 3/28/26, is 15 which indicates R91 is cognitively intact. R99's face sheet documents diagnoses that include but are not limited to cardiomyopathy, heart failure and depression. R99's BIMS (brief interview for mental status) score, dated 3/20/26, is 15 which indicates R99 is cognitively intact. On 4/4/26 at 10:32am, R99 said, I'm not surprised the faucet in my bathroom is that way (in disrepair). I don't use it (bathroom), but other people do. I bet the staff don't live like this. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/5/26 from 9:28am to 9:46am, surveyor and V8 (Maintenance Director) took a tour of the facility and observed R7, R15, R23, R72, and R110 lacked overhead lighting and/or the overhead light fixture was not operational at the time of observation. V8 said, These lights don't work. I'm not sure for how long. I ordered them, but they are on back order. Yes, every resident should have some type of overhead lighting. Once the lights are not on backorder, every resident will have one (overhead lighting). Also observed was a damaged metal faucet with frayed, sharp edges in the shared bathroom for R8, R91, and R99. V8 said, Oh. That's bad. I was not aware of this. If I was aware, we wouldn't be looking at this right now. Yeah, that's pretty sharp. Someone can cut themselves. I will get this (faucet) changed right away. Record review of facility policy titled, Preventative Maintenance, dated 1/01/26, documents, in part, A Preventative Maintenance Program shall be developed and implemented to ensure the provision of a safe, functional, sanitary, and comfortable environment for residents and staff, and the public. The Maintenance Director is responsible for developing and maintaining a schedule of maintenance services to ensure that the buildings, grounds, and equipment are maintained in a safe and operable manner. The Maintenance Director shall assess all aspects of the physical plant to determine if Preventative Maintenance (PM) is required. Required PM may be determined from manufacturer's recommendations, maintenance requests, grand rounds, life safety requirements, or experience. If preventative maintenance is required, the Maintenance Director shall decide what tasks need to be completed and how often to complete them. Record review of facility job description titled, Maintenance Director, dated 10/11/2019, documents, in part, The primary purpose of the Maintenance Director is to plan, organize, develop, and direct the overall operation of the Maintenance Department in accordance with current, federal, state and local standards, guidelines, and regulations governing our facility, and as may be directed by the Administrator, to assure that our facility is maintained in a safe and comfortable manner. Repair facility/resident property as necessary. In the event of inability to repair coordinate with outside vendors to make repair or replace as cost effectively as possible. Also ensure that services provided by outside vendors are properly completed/supervised in accordance with contracts/work orders. Record review of pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, in part, 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. 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. On 5/4/26 at 10:35am, oatmeal was noted to be splattered across the floor in R1's room - which was near the door. On 5/4/26 at 10:37am, surveyor inquired about the substance on R1's floor. V14 (Licensed Practical Nurse) subsequently entered the room and stated, Is it oatmeal, cereal? It's some type of oatmeal or something on the floor. (continued on next page)		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145718	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2026
NAME OF PROVIDER OR SUPPLIER Thryve of Crestwood		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The safe and homelike environment policy (reviewed 1/14/25) states housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, and record review the facility failed to follow policy procedures, failed to identify safety hazards, failed to implement fall prevention interventions, and/or failed to provide supervision for five of 42 residents (R1, R12, R16, R33, R84) in the sample reviewed for falls/hazards. Findings include: R16 was hospitalized on [DATE] for an unwitnessed fall in his room with a closed head injury and head laceration with repair above the left eye with five sutures in place. R16 is [AGE] years of age. Current diagnoses include but are not limited to Dementia, Seizures, Essential Hypertension, Anemia, and Protein Calorie Malnutrition. R16's comprehensive assessment section C Cognitive Patterns dated 08/22/2025 documents a (BIMS) brief interview for mental status score of 6 out of 15 which indicates severe cognitive impairment. This suggests significant challenges with memory, orientation, and decision-making abilities. This was the documented BIMS score prior to the fall. On 05/05/2026 at 11:42 AM, V27 CNA Certified Nurse Assistant was inquired of R16. V27 CNA said, R16 can be dressed with one person but transfer will need one to two staff. He does try to get up without help. On 05/05/2026 at 11:50 AM, R16 is lying in bed with a call light in reach. No fall mat on floor next to either side of the bed in the room. On 05/06/2026 at 1:19 PM, V26 RN Registered Nurse was inquired of R16's fall on 11/23/2025. V26 said, He (R16) needs assistance with one person to get out of bed and transfer. He always tried to get up. He was trying to get into his wheelchair. It was early in the morning at the start of my shift. That day he was trying to get up by himself. V41 CNA Certified Nurse was his aide; she was in another room helping a resident. I did my rounds that morning and he was still in bed, and it was in a low position. When he fell, he hit his head. He was on the floor near the bed on his right side. He was talking, he said he was trying to get to the wheelchair. The aides try to change him and get him up quickly because he tries to get up. He keeps doing that all the time. The call light was in his bed. The problem was sometimes he doesn't know how to use the call light, other times he tries to get up without using it. He was alert x 1 to 2 (to person and place), that day he didn't use the call light. It was around shift change early in the morning between 7:30 - 8 AM. On 05/06/2026 at 1:35 PM, V25 Restorative Nurse was inquired of R16's fall on 11/23/2025. V25 said, He (R16) was a high fall risk. It's because of his BIMS (Brief Interview for Mental Status) score 3 and Dementia. He needed assistance with one person to transfer. He could stand and pivot with extensive assistance of one person. He wasn't able to walk independently. This was the very first time he attempted to walk independently. His fall preventions were a Dycem in the wheelchair, encourage to change position slowly with partial assistance, keep call light within reach, keep immediate environment clutter free, and adequate lighting. He didn't have floor mats because staff were getting him in and out his (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wheelchair and he could self-propel his wheelchair once he was in it. He wouldn't be able to understand how to use the call light. I'm not sure if he'd be able to remember all the time. V25 Restorative Nurse confirmed R16 was unable to understand or remember how to use his call light due to his diagnosis of Dementia and low BIMS score identifying his severe cognitive impairment. On 05/06/2026 at 3:00 PM, V41 CNA Certified Nurse Assistant was inquired of R16's fall on 11/23/2025. V41 said, I did my rounds at 6:30 and got all my stuff that morning. He (R16) gets up right before breakfast. I came back from helping another resident and the nurse said he was on the floor. I went in his room earlier and he was in bed. He's a stand and pivot, but he does try to get up by himself. He can self-propel his own wheelchair and often tries to put himself back to bed. That's why we have to keep redirecting him. He's demented, I don't think he knew how to use his call light, but there wasn't a visible call light in the room. There wasn't a call light in his wall. I worked there for a year, and he always used to put himself back in bed after he eats unless he was going to smoke. On 05/07/2026 at 11:08 AM, V1 Administrator was inquired of R16's nurse practitioner V64 who documented his post fall evaluation. V1 said, She resigned a couple of weeks ago and moved out of town. V1 provided the contact information for R16's physician V63 Physician. On 05/07/2026 at 11:12 AM, V63 Physician was called and inquired of R16's fall from 11/23/2025. V63 said, I'm driving now but I can call you back after 1PM if that's OK. On 05/07/2026 at 11:44 AM V64 NP Nurse Practitioner regarding R16's 11/23/2025 fall. V64 said, I no longer work with that facility and don't have access to my notes. I don't recall the circumstances around his (R16's) fall unfortunately. On 05/07/2026 at 4:31 PM, V67 Physician was inquired of R16's 11/23/2025 fall. V67 said, I spoke with V2 DON Director of Nursing. He (R16) has Dementia and was found on the floor with a cut on his forehead. They sent him to the hospital, and he got stitches. His bed was low. A while ago he was falling and tripping over the floor mat, so he didn't have one when he fell. They had PT (physical therapy) to see him and moved him closer to the nurse's station after the fall. It would depend on how bad his Dementia is if he could even use the call light because they forget things. Having him visible to staff may have helped. The 11/23/2025 fall scene investigation report states in part: R16 had an unwitnessed fall, was found on the floor next to his bed after attempting to self-transfer alone and unattended. He has dementia but is alert and oriented x 2 (person and place). Neurological examinations reviewed from 11/23/2026 - 11/26/2026. Witness statements from staff on 11/23/25 reviewed. Fall risk assessment from 8/27/2025 (prior to the fall) indicates R16 is a high fall risk. Urinalysis and urine culture indicated elevated white blood cells. R16's fall incident documentation of the fall on 11/23/2025 by V26 RN was reviewed. V26 documented R16 stated, R16 tried to get his ass out the bed. Progress notes document R16 was prescribed ABT (Antibiotic) Amoxicillin-Pot Clavulanate Tablet 875-125 MG 1 tablet by mouth two times a day for prophylaxis for urine, WBC (White Blood Count) lab (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	result, and left eye sutures for 7 Days. Hospital discharge documentation indicates closed head injury with head laceration to left eye with five sutures in place. R16's follow up Nurse Practitioner evaluation by V64. 12/1/2025 15:45 np subsequent visit Date of Service: 12/01/2025 03:45 PM Visit Type: NP SUBSEQUENT VISIT Transition of Care: N/A History Details: N/A Details: NP Subsequent Visit PROVIDER: V64, N.P. PATIENT NAME: R16 FACILITY: REHABILITATION CENTER, LLC date of birth : 12/05/1953 DATE OF SERVICE: 12/01/2025 CHIEF COMPLAINT: follow-up post fall, facial laceration HPI: Pt is a [AGE] year-old AA male with a pmhx (past medical history) detailed below who has been a LTC (long term care) resident of Nursing Rehabilitation Center on the Men's Village memory care unit since 10/2018. He is seen and examined today for a follow-up visit for a fall that occurred on 11/23. He was seen in the ED (emergency department) for evaluation at the time of fall and received sutures to the forehead laceration. Today, he is seen lying in bed today. He is aox1, forgetful, pleasant and cooperative, Afevss (Afebrile, vital signs stable), in NAD (No acute distress). His neuro status is baseline. He denies pain or headache. There continues to be mild bruising around laceration and left eye that is improving. Forehead laceration with sutures intact, no redness, warmth, boggy, or drainage noted. See wound rounds for detailed assessment. IDNP (Infectious Disease Nurse Practitioner) placed pt (patient) on Augmentin BID (twice a day) x7 days and he is tolerating antibiotic well with no adverse reactions. His blood pressure is stable on his current medication. No respiratory distress is noted. He denies fevers, malaise, dizziness, CP (chest pain), cough, SOB (shortness of breath), abdominal pain, NVDC (nausea, vomiting, diarrhea, constipation), or dysuria. Staff report no behaviors, issues, or concerns at this time. PAST MEDICAL HISTORY: Other Seizures Unspecified Protein-calorie Malnutrition Obstructive And Reflux Uropathy, Unspecified Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, And Anxiety Essential (Primary) Hypertension Unspecified Sequelae Of Unspecified Cerebrovascular Disease Major Depressive Disorder, Single Episode, Unspecified Benign Prostatic Hyperplasia With Lower Urinary Tract Symptoms Unspecified Hydronephrosis Encounter For Screening For Covid-19 Anemia, Unspecified Disorder Of Adrenal Gland, Unspecified Benign Neoplasm Of Right Kidney Allergic Rhinitis, Unspecified Vitamin Deficiency, Unspecified Gastro-esophageal Reflux Disease Without Esophagitis Hyperlipidemia, Unspecified Contact With And (Suspected) Exposure To Covid-19 Cellulitis Of Right Lower Limb Covid-19 Gross Hematuria Contact With And (Suspected) Exposure To Other Viral Communicable Diseases PAST SURGICAL HISTORY: non-contributory SOCIAL HISTORY: non-contributory FAMILY HISTORY: non-contributory CODE STATUS: Code Status: Full Code ALLERGIES: No Known Drug Allergies MEDICATIONS: Valproic Acid Capsule 250 MG two times a day Multivitamin Tablet one time a day Loratadine Tablet 10 MG one time a day Donepezil HCl Tablet 10 MG at bedtime Simvastatin Tablet 20 MG at bedtime Tamsulosin HCl Capsule 0.4 MG at bedtime Propranolol HCl Tablet 10 MG one time a day hydrochlorothiazide Tablet 25 MG one time a day Ferrous Sulfate Tablet 325 (65 Fe) MG two times a day levETIRacetam Tablet 1000 MG one time a (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dayAspirin Oral Capsule one time a dayTriamcinolone Acetonide External Cream 0.1 % two times a dayTylenol Extra Strength Oral Tablet 500 MG as neededPantoprazole Sodium Oral Tablet Delayed Release 20 MG one time a dayAmoxicillin-Pot Clavulanate Tablet 875-125 MG two times a dayLABS: reviewedIMAGING: No imaging data availableREVIEW OF SYSTEMS (ROS): A 14 point review of systems was completed and negative except as documented in HPIPHYSICAL EXAMINATION: Vitals - T 97.2, BP 118/67, HR 69, R 18, O2 SAT 97%General - well developed, well-nourished, in NAD, AOx1 (alert, oriented x 1 (to self))Eyes: Conjunctivae are anicteric, lids are normal. EOMI (Extraocular movements intact)Ears, Nose, Mouth, Throat: External inspection of ears and nose is normal.Respiratory: Normal respiratory effort. No accessory muscle use. No audible wheezing.CV: regular, S1 S2, no BLE (bilateral lower extremity) edemaABD: Soft, non-tender, +BS (bowel sounds)Skin: No visible skin lesions or rashes noted in exposed BUE or BLE. Forehead laceration w suturesMSK: No asymmetry or masses noted in b/l (bilateral) UE (upper extremity) and LE (lower extremity).Muscle strength: moves all 4 extremities against gravity. Grossly normal tone.Neuro: Good coordination in extremities.Psych: Normal mood. Normal affect. Patient responds appropriately to examiner. Judgment and insight appear grossly impaired.ASSESSMENT/PLAN: Unspecified fall, initial encounter (W19.XXXA)Laceration without foreign body of other part of head, initial encounter (S01.81XA)Unspecified dementia without behavioral disturbance (F03.90)-neuro checks per facility protocol-monitor laceration for s/s infection-continue Augmentin per ID (Infectious Disease) recs-Tylenol for pain-wound care following-encourage PO (by mouth) fluids-continue double protein and nutritional supplements w meals.-chart reviewed-medications reviewed; continue current medication regimen-maintain seizure, safety and fall precautions-monitor for changes in CV (cardiovascular)/resp, GU (Genitourinary), neuro status or behavior/mood-cardiology NP (nurse practitioner) following-Palliative care NP following-discussed with pt (patient), nursing---Time of the note does not necessarily correlate to the time the patient was seen.Total time spent reviewing obtained history and/or testing, examining and evaluating patient, counseling/educatingpatient/family/caregiver, providing orders, independently interpreting results/communicating results withpatient/family/caregiver, and coordinating care not separately reported: 30 MinutesMIPS 130 - Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient'scurrent medications---V64, N.P.Provider: V64, N.P.Signed Date: 12/01/2025 03:50 PM R16's comprehensive assessment section GG Functional Abilities dated 08/22/2025 documents the following: He uses a wheelchair. Mobility: C. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed and with no back support. 04. Supervision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. D. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.04. Supervision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).04. Supervision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	completes activity. Assistance may be provided throughout the activity or intermittently. I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. 09. Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. Care plan R16 is at HIGH risk for falls and fall injuries 02/24/2023. Goal: R16 will not fall leading injury through next review 06/23/2025. Revised post fall: The facility will reduce/minimize falls causing injury to R16 through next review 11/23/2025. Interventions: Encourage R16 to transfer and change positions slowly 02/24/2023. Revised post fall: Encourage R16 to change positions slowly with partial assist x 1 staff participation 11/23/2025. Get to know R16's habits to anticipate needs 02/24/2023. Keep call light within reach and instruct R16 to use it for assistance. Educate on how to use call light and receive a return demonstration 02/24/2023. Keep resident in visible view of staff as resident will allow 12/29/2023. R16 has impaired cognitive function/dementia r/t Dementia 05/24/2022. Goal: R16 will maintain current level of cognitive function through the review date. Interventions: Identify yourself at each interaction, face resident when speaking and make eye contact. Reduce any distractions- turn off TV, radio, close door etc. the resident understands consistent, simple, directive sentences 07/31/2019. Keep The resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion 07/31/2019. R16's care plan documents interventions that are not effective (education and use of call light) and were not implemented on 11/23/2025 related to R16's diagnosis of Dementia and BIMS (Brief Interview for Mental Status) score of 6 indicating severe cognitive impairment. V26 RN Registered Nurse and V41 CNA Certified Nurse Assistant confirmed R16 routinely attempted to transfer himself unassisted numerous times. Staff did not implement R16's fall care plan interventions as documented. R33 is [AGE] years of age. Current diagnoses include but are not limited to Traumatic Subdural Hemorrhage with Loss of Consciousness, Epilepsy, Alcohol Use with Withdrawal Delirium, Dementia, Depression, Nicotine Dependence, Fall with Head Injury, and Hypertension. R33's comprehensive assessment section C Cognitive Patterns dated 03/31/2026 documents a (BIMS) brief interview for mental status score of 8 out of 15 which indicates moderate cognitive impairment. On 05/05/2026 at 12:01 PM, R33 is in his room with a cigarette behind his ear. R33 said, I'm waiting to go smoke, do you know when it is? On 05/05/2026 at 2:31 PM, V26 RN Registered Nurse was inquired of R33 having a cigarette in his possession. V26 RN said, Sometimes the family comes and gives them their cigarettes, but because of him having dementia staff takes them to their breaks. We usually don't allow that. On 05/05/2026 at 3:01 PM, V27 CNA Certified Nurse Assistant was inquired of R33 having a cigarette in his possession. V26 said, He (R33) is allowed to leave this side of the unit and walk around on 4th (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	floor. He visits his friends and asks them for a cigarette so that's probably how he got it. We keep them (cigarettes) at the receptionist desk in a box downstairs. On 05/06/2026 at 2:46 PM, V5 Social Service Director was inquired of R33 smoking contract. V5 said, He's (R33) a supervised smoker. V28 Activity Aide brings the residents down to smoke. V28 gets the cigarettes from the receptionist at the front desk, and they're labeled. He walks the residents outside, hands them cigarettes and lights them. Because of his cognition and Dementia, it's not safe for him to have his smoking materials. R33's 01/01/2026 Smoking Risk Observation documents he is a supervised smoker. R33's signed Resident Smoking Contract dated 01/14/2026 states in part: Based on an interdisciplinary team assessment, possession and storage of my smoking materials will be as follows: b. May not carry smoking materials or lighters. Smoking materials will be labeled with the resident's name at the nursing station or other designated area. R1's diagnoses include bipolar disorder. R1's (2/1/26) BIMS (Brief Interview Mental Status) determined a score of 12 (moderate impairment). On 5/4/26 at 10:39am, 3 razors were observed on R1's bathroom sink (unattended by staff). Surveyor inquired if residents are allowed to have razors in their possession V14 (LPN/Licensed Practical Nurse) stated No. Surveyor inquired how many razors were on R1's sink V14 responded Three. --- On 5/4/26 at 11:02am, the curtain rod in R84's room appeared bent, falling down, and the left side was leaning against the wall. Upon further inspection, the curtain rod was not secured on the hook - it was completely off. Surveyor inquired about safety concerns with R84's dangling curtain rod V15 (LPN) stated The rod is off of the part that it sits on. Surveyor inquired if V15 was able to open R84's curtain at this time V15 responded I'm (V15) not gonna do that, it's gonna fall. --- R12's diagnoses include cerebral ischemia and metabolic encephalopathy. R12's (3/22/26) BIMS determined a score of 15 (cognition intact). On 5/4/26 at 12:21pm, a pack of cigarettes was observed in R12's hoodie pocket. Surveyor inquired how many cigarettes were in the pack R12 stated It's a new pack. Surveyor inquired how R12 obtained the cigarettes R12 responded Somebody brought it in, my sister. Surveyor inquired if residents are allowed to have cigarettes in their possession, R12 replied Not really, they normally be at the front desk downstairs in the drawers. On 5/4/26 at 12:30pm, surveyor inquired if residents are allowed to have cigarettes in their (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	possession V14 (LPN) stated Yes. Surveyor inquired if residents are allowed to have smoking paraphernalia (cigarettes, cigars, lighters, etc.) in their possession V14 responded Oh, no. On 5/6/26 at 8:34am, surveyor requested the policy for razor containment V1 (Administrator) responded We (facility) only got like the homelike environment policy. Surveyor inquired where razors should be contained, V1 replied After they are used? in the sharps container. On 5/6/26 at 9:35am, surveyor inquired if residents are allowed to have cigarettes in their possession V6 (Activities Director) stated Not no more, since (facility name) took over they (residents) can't have them. I (V6) don't think we (staff) have all their (residents) cigarettes cause family will bring them but the smoking materials are kept at the front desk. Surveyor inquired if residents are allowed to have razors in their possession V6 responded No, the CNAS (Certified Nursing Assistants) have em and most of the time they (CNAS) shave them (residents). Surveyor inquired where razors are disposed V6 responded I (V6) think they got a box for em. FALL PREVENTION AND MANAGEMENT policy reviewed on 2/2026 states in part: GENERAL: This facility is committed to maximizing each resident's physical, mental, and psychosocial well-being. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible. All resident falls shall be reviewed, and the resident's existing plan of care shall be evaluated and modified as needed. RESPONSIBLE PARTY: RN, LPN, DON GUIDELINES Upon admission: A fall risk evaluation will be 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. Smoking Policy Effective Date: January 2023 Review Date: January 2026 PURPOSE: To establish guidelines to prohibit smoking by residents and visitors in the building except in designated areas. To establish guidelines for the specific circumstances in which residents may (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Thryve of Crestwood		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	smoke in the designated areas and when increased supervision is required. Policy Specifications: 1. All residents who desire to smoke will be assessed by the Interdisciplinary Team to determine if the individual is appropriate for independent smoking. 2. If assessed to be appropriate for independent smoking, the resident must sign a Facility Smoking Contract. 3. If a resident breaks the smoking contract the facility may revoke the residents' smoking privilege. 5. Some residents may require more intensive staff supervision while smoking. These residents smoke separately from other residents, under the supervision of a staff member specifically designated to assist them. Behaviors that may trigger additional resident supervision while smoking include, but are not limited to: - Being unable to state facility smoking rules - Being unable to follow facility smoking rules without prompts - Using smoking materials in an inappropriate manner - Giving or selling cigarettes and/or smoking materials to other residents - Collecting or attempting to use discarded smoking materials - Asking for smoking materials from other residents - Attempting to take other residents' smoking materials - Attempting to intimidate another resident for the purpose of taking cigarettes or smoking materials 7. Possessing, carrying, or holding materials used to smoke (including, but not limited to, cigarettes, cigars, loose tobacco, pipes, lighters, and matches) by residents is prohibited inside the building. Residents must give smoking materials to designated staff when they enter the building, even if the resident has been assessed to be independent in carrying such materials when off the premises. 8. Residents are prohibited from giving smoking materials to other residents. 9. Residents are prohibited from asking other residents for smoking materials. 10. The facility may limit smoking to designated times for both independent and supervised residents. The safe and homelike environment policy (reviewed 1/14/25) states maintenance services will be (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provided as necessary to maintain a sanitary, orderly and comfortable environment. Report any unresolved environmental concerns to the Administrator. The (November 2013) resident smoking policy states persons bringing smoking materials into the facility for resident's use must leave these items at the front desk. Smoking materials left for an individual resident will be labeled and forwarded to an assigned staff member. The (03/01) contraband policy states 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: cigarettes, razor blades.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to have a policy/procedures for maintaining respiratory equipment, failed to ensure that respiratory equipment was discarded weekly, and failed to maintain respiratory equipment in a bag when not in use for four of 42 residents (R1, R108, R135, R190) in the sample reviewed for respiratory care. Findings include: 1) R108 is [AGE] years old and has resided at the facility since 2025. Past medical history includes but is not limited to chronic obstructive pulmonary disease with acute exacerbation, other specified disorders of muscle, essential primary hypertension, type 2 diabetes, anemia, hyperlipidemia, chronic respiratory failure, need for assistance with personal care, etc. On 05/04/2026 10:05AM, R108 was observed in room, awake and alert stated that she is doing okay, just that she is on antibiotics for upper respiratory infection and just got over pneumonia. R108 said that she is tired of being sick. On 05/04/2026 10:27AM, observed incontinence care for R108 with V10 (CNA) and V17 (Restorative aid). V10 removed resident's CPAP mask that was on her bed and placed it directly on top of the CPAP machine without it being contained. On 5/5/2026 at 9:55AM, R108 was observed in bed, awake and alert and stated that she is doing okay, respiratory mask was observed in a plastic bag, R108 said, that only happened because State is in the building otherwise, they usually leave it uncontained all the time. Active physician order dated 4/30/2026 documents the following: per record review, R108 is on the following medication: Levaquin tablet 500 MG (Levofloxacin) give 1 tablet by mouth one time a day for respiratory infection for 7 Days. 2) R190's (4/2/26) BIMS (Brief Interview Mental Status) determined a score of 15 (cognition intact). On 5/4/26 at 10:13am, R190's nebulizer mask was observed on the dresser uncontained, and the tubing was dated 3/16/26. Surveyor inquired when R190's respiratory equipment is changed/replaced R190 stated They (staff) do change the tubing once in a while. On 5/4/26 at 10:15am, surveyor inquired if R190's nebulizer mask was contained in a bag. V13 (LPN/Licensed Practical Nurse) stated, No, it's not but I (V13) can do it. Surveyor inquired about the date on R190's nebulizer tubing. V13 responded, 3/16/26 (49 days ago). Surveyor inquired when should nebulizer tubing and/or masks be changed. V13 replied, Weekly. On 5/4/26 at 10:35am, R1's nebulizer mask was observed uncontained on the windowsill. R1's nebulizer mask was dated 4/3 (roughly 1 month ago). (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/4/26 at 10:37am, surveyor inquired about concerns with R1's nebulizer mask. V14 (LPN) stated, The date is April 3rd. Surveyor inquired if R1's nebulizer mask was contained while not in use V14 responded No, it's not in a bag. On 5/4/26 at 10:49am R135's uncontained Bipap mask was observed on the dresser. Surveyor inquired if R135's Bipap mask was contained while not in use. V13 (LPN) stated, No, it should be in a bag. On 5/6/26 at 8:34am, surveyor requested the respiratory equipment (re: Nebulizer, Bipap, Cpap) policy. V1 (Administrator) stated, I (V1) don't have one for the respiratory equipment. Surveyor inquired where respiratory equipment should be stored when not in use. V1 responded, It can be contained in a plastic bag due to infection control purposes. On 5/6/26 at 4:51pm, surveyor inquired when nebulizer masks/mouthpiece should be changed. V2 (Director of Nursing) stated, My (V2) protocol is that we (staff) do it weekly. Surveyor inquired how respiratory equipment should be stored when not in use. V2 responded, If it's not in use, we put it in a bag. The oxygen safety/use policy (reviewed 1/2026) states oxygen tubing will be changed weekly and appropriately stored to prevent contamination when not in use.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to immediately sign out controlled substances prior to administration and failed to maintain documented accountability for controlled substances not in use. These failures affected four residents (R14, R87, R119, R11), and seven discharged residents (R214, R215, R216, R217, R218, R219, R220) in a sample of 63 residents. Findings Include: On 5/5/2026 at 4:50 PM, V3, Assistant Director of Nursing (ADON) was assigned to care for patients that received medication from the cart and had taken possession of the cart key following shift change. Observed medication cart with V3. Observed controlled medication count and reviewed the controlled drug receipt/record/disposition forms with V3. Observed the following discrepancies with V3: A) R14 - Tramadol 25mg (milligram), 19 tablets available. According to the controlled drug receipt/record/disposition form, 20 tablets should be present. Additionally, the back of the medication card revealed a patient label for a different resident. B) R119 - Pregabalin 75mg, 2 capsules available. According to the controlled drug receipt/record/disposition form, 3 capsules should be present. C) R87 - Clonazepam 1mg, 3 tablets available. According to the controlled drug receipt/record/disposition form, 4 tablets should be present. These discrepancies were confirmed with V3. V3 affirmed controlled medications should be signed out on the Controlled Drug Receipt/Record/Disposition Form immediately upon removal of the controlled medication to be sure of an accurate count. On 5/5/2026 at 4:55 PM, V52 (Registered Nurse) confirmed being the day shift nurse and said they should have signed the medications out at the time they were given in the morning but forgot to do so before shift change and did not count with V3 before handing off the medication cart keys. V52 stated that medications were administered to R87 and R119 during the 9am med pass but could not recall administering the Tramadol to R14. When asked about the protocol of signing out the controlled medications on the Controlled Drug Receipt/Record/Disposition Forms, V52 stated that the medications should be signed as you go (documented when medication is withdrawn from the cart to administer) and not multiple hours later. Record review of Medication Administration Records (MAR) for R14, R87, and R119 show the following medications were administered on 5/5/26: R14 - Tramadol 25mg was administered by V52 at 1:30PM. R87 - Clonazepam 1mg was administered by V52 at 09:00AM. R119 - Pregabalin 75mg was administered by V52 at 09:00AM. On 5/6/26 at 9:10AM, surveyors identified an unmarked storage room with V47 (Central Supply Manager) in search of incontinence briefs. V47 referred to the room as a supply overstock room. Upon entry, there was a large quantity of medications scattered around the room amongst general supplies such as personal protective equipment, oxygen tubing and rolls of garbage bags. Large drawers filled with medication blister pack from the pharmacy were visualized along the right wall. Multiple brown boxes contained additional packs of resident-specific medications, and three boxes of various injectable medications were on a table. Medications dispensed from current and previously used pharmacies and included controlled medications. There were no Controlled Drug Receipt/Record/Disposition forms accompanying the controlled medications, nor a tracking system/log of the medications present in the room. On 5/6/26 at 9:15AM, V29 (Nursing Unit Manager) was called to the room and said the facility recently changed pharmacy companies and that some of the medications in the room were from the old pharmacy and awaiting to be returned, some were discontinued medications and no longer needed, and some medications were being held for residents that were currently hospitalized. V29 said the policy was that medications would be held for 10 days before returning them to the pharmacy. V29 (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	said the medications have been in the room for at least two weeks awaiting pick-up. On 5/6/26 at 9:21AM, V2 DON (Director of Nursing) confirmed there should be no controlled medications in this room, and any discontinued controlled medications should have been destroyed. The other medications were to be sent back to the pharmacy for disposal and reimbursement. V2 stated that V29 is responsible for coordinating the pickup with the pharmacy for the other remaining medications. Controlled medications present in the unmarked storage room without the accompanying Controlled Drug Receipt/Record/Disposition Form Include: R11 - Lorazepam 2mg IM Injection vials. R11 is currently residing in the facility. R214 (according to face sheet discharged [DATE]) - Buprenorphine HCl-Naloxone HCl Sublingual Films R215 (discharge date unknown) - Lorazepam 2mg/ml liquid. Physician's order sheet indicates medication was discontinued 11/3/25. R216 (a discharged resident) - one unopened box of five Fentanyl patches 12mcg (micrograms). R217 (a discharged resident) - Midazolam Nasal Spray. R218 (a discharged resident) - Dronabinol 2.5mg capsules R219 (a discharged resident) - Lacosamide 100mg tablets R220 (a discharged resident) - Lorazepam 2mg/ml liquid Face sheets, Medication Administration Records and Physician Order Sheets were requested to investigate the accounting for all controlled medications. On 5/6/26 V50 [NAME] President of Clinical Operations said R214, R215, R216, R217, R218, R219 and R220 had been discharged from the facility and many of the records for the residents could not be found due to change of ownership twice over. Facility Controlled Substance Policy (reviewed 5/2026) states in part; General: Medications classified by the FDA as controlled substances have high abuse potential and may be subject to special handling, storage, and record keeping. Policy: 1. Only authorized personnel involved in the residents care will have access to medication. The Director of Nursing is responsible for the control of these medications. 11. All schedule II-controlled substances (and other schedules if facility policy so dictates) will be counted each shift or whenever there is an exchange of keys between off-going and on-coming licensed nurses. The two nurses will: a. Inspect both the drug package and the corresponding count sheet to verify the accuracy of the amount remaining. b. Both nurses will count the number of packages of controlled substances that are being reconciled during the shift/shift count and document on the Shift Controlled Substance Count Sheet. c. Both nurses will count the Controlled Substances count sheets and verify the accuracy of the number of remaining count sheets. d. Both nurses will sign the Shift/Shift Controlled Substance Count Sheet acknowledging that the actual count of controlled substances and count sheet matches the quantity documented.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to follow policy procedures, failed to store medications safely/securely, failed to make sure medications were not accessible to unauthorized individuals, and failed to make sure controlled substances were double locked for two of 42 residents (R1, R11) in the sample and seven of 63 residents (R214, R215, R216, R217, R218, R219, R220) in the supplemental sample reviewed for medication storage. Findings include: R11's (2/26/26) BIMS (Brief Interview Mental Status) determined a score of 15 (cognition intact). On 5/4/26 at 10:23am, a medication cup - which contained a white liquid was observed on R11's bedside table. Surveyor inquired what was in the medication cup. R11 stated, Milk of Magnesia I (R11) believe they call it, its gonna make you poop. Surveyor inquired how long the medication was sitting on the table R11 responded, Since yesterday. On 5/4/26 at 10:30am, surveyor inquired about the Milk of Magnesia left at R11's bedside. V14 (LPN/Licensed Practical Nurse) responded, I'm (V14) not sure if its Milk of Magnesia. Surveyor inquired if staff are allowed to leave medications at resident's bedside. V14 replied, No. — On 5/4/26 at 10:35am, a white pill was observed on R1's windowsill. On 5/4/26 at 10:37am, surveyor inquired about the pill on R1's windowsill. V14 (LPN) stated, I'm (V14) not sure what med (medication) it is. V16 (Minimum Data Set Coordinator) subsequently inspected the pill and responded, It looks like a calcium pill. — On 5/4/26 at 12:53pm, a Symbicort inhaler was observed on R11's bedside table. R11's (9/17/25) physician order includes Symbicort every 12 hours (may keep at bedside is excluded). On 5/4/26 at 12:54pm, surveyor inquired about the medication left on R11's table. V14 (LPN) entered the room, inspected the inhaler and stated, Symbicort. Surveyor inquired (again) if staff are allowed to leave medications at bedside. V14 responded, No. On 5/6/26 at 4:49pm, surveyor inquired if medications are allowed to be left at bedside. V2 (Director of Nursing) stated, No, ma am. On 5/6/26 at 9:10AM, surveyors inspected an unmarked storage room with V47 (Central Supply Manager) in search of incontinence briefs. V47 referred to this room as supply overstock room. There (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was a numeric keypad entry to the door. Upon entry, there was a large quantity of medications scattered around the room, among general supplies such as personal protective equipment, oxygen tubing, and rolls of garbage bags. Two large drawers filled with medication cards from current and previous pharmacy were visualized along the right wall. Multiple brown boxes contained additional packs of patient-specific medications, and three boxes of various injectable medications were on a table. Medication review revealed both controlled and non- controlled medications. There were no Controlled Drug Receipt/Record/Disposition forms accompanying the controlled medications, nor a tracking system/log of the medications present in the room. Controlled medications were not secured by a second lock within the room. V47 was not licensed to access medication rooms or supplies. V47 stated that surplus supplies are put in this room on the 2nd floor, and that the manager of the unit has access to the room as well. On 5/6/26 at 9:15AM, V29 (Unit Manager/Licensed Practical Nurse) came to the unmarked storage room. V29 stated all of these medications were either from the previous pharmacy and awaiting return to there, discontinued medications/no longer needed from current pharmacy, or medications remaining from patients that have been hospitalized longer than 10 days. V29 confirmed that pharmacy was called within the last 2 weeks for pickup but pick up date is unknown. V29 had access to this room via the numeric keypad. On 5/6/26 at 9:21AM, V2 (Director of Nursing) observed the medications in the storage room. V2 stated that the facility underwent a transition of pharmacies in recent weeks but is unsure of the exact date. V2 denied having access code to this room and was unaware of the quantity/types of medications in the room. When asked if there should be controlled medications in this room, V2 confirmed that any discontinued controlled medications should have been destroyed, not stored. V2's understanding is that V29 was utilizing this room as an office, and that V47 should not have access to medications. On 5/6/26 at 10AM, V50 (VP of Clinical Operations) observed the ongoing inspection of the medications in the supply room. V50 affirmed that unlicensed personnel should not have access to these medications. The (2/2026) medication storage policy states medications and biologicals are stored safely, securely, and properly following the manufacture or supplier recommendations. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Policy Medication Storage in the Facility (1/2023) documents in part .Medication rooms, carts, and medication supplies are locked or attended by person with authorized access: Licensed Nurses, Consultant Pharmacist, Pharmacist Technician, Individual lawfully authorized to administer drugs, Consultant Nurses. Also, the policy states All drugs classified as Schedule II of the Controlled Substances Act will be stored under double locks. Schedule II-V medications must be maintained in separately locked permanently affixed compartments and cannot be stored with other nonscheduled medications.		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the failed to provide a thermometer for a resident's personal refrigerator; failed to date outside open food items in a resident's personal refrigerator; failed to clean residents' refrigerators; and failed to discard expired food items from a resident's personal refrigerator. These failures affected 6 residents (R3, R4, R8, R89, R91, and R163) reviewed for safety of personal food items, in a total sample of 63 residents. Findings include: R4's face sheet documents diagnoses that include but are not limited to history of falling, need for assistance with personal care, disorder of muscle, and reduced mobility. R4's BIMS (brief interview for mental status) score, dated 4/8/26, is 12 which indicates R4's cognition is moderately impaired. On 5/4/26 at 10:21am, observation of R4's personal refrigerator revealed an undated Styrofoam take-out container with partially eaten ribs and partially eaten fried onion blossom and an undated Styrofoam take out container of partially eaten grits (the word grits written on top of container). R4 said, those (take out containers) have been in there a few days. Not sure (how long). The grits definitely need to be thrown out. The CNAs usually are in there (personal refrigerator) checking things out. No, not every day. R163's face sheet documents diagnoses that include but are not limited to central cord syndrome at unspecified level of cervical spinal cord, fusion of spine, fall, and paraplegia. R163's BIMS (brief interview for mental status) score, dated 3/26/26, is 15 which indicates R163 is cognitively intact. On 5/4/26 at 10:30am, observation of R163's personal refrigerator revealed no thermometer to check the temperature of the fridge. R163 said, They (staff) checked it (personal refrigerator) today. There hasn't been a thermometer in my fridge for a while now. R8's face sheet documents diagnoses that include but are not limited to chronic obstructive pulmonary disease, depression, and acquired absence of right leg. R8's BIMS (brief interview for mental status) score, dated 4/24/26, is 15 which indicates R8 is cognitively intact. On 5/4/26 at 10:32am, observation of R8's personal refrigerator revealed an undated Styrofoam take-out container of hot wings and bread that is wrapped in undated aluminum foil. R8 said, Ha Ha! I don't even know what day it is, so I'm not really sure how old that stuff it is. R91's face sheet documents diagnoses that include but are not limited to prediabetes, weakness, and seizures. (continued on next page)		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R91's BIMS (brief interview for mental status) score, dated 3/28/26, is 15 which indicates R91 is cognitively intact. On 5/4/26 at 10:34am, observation of R91's pink personal refrigerator revealed no thermometer to check the temperature of the fridge. On 5/4/26 at 10:43am, V4 (Infection Preventionist/Unit Manager) said, I'll get thermometers for the personal refrigerators. Yes, they (personal refrigerators) all should have thermometers to make sure the food doesn't spoil. The outside food (personal refrigerators) should be dated. We (facility) usually keep it only 3 days. To prevent residents from getting a food borne illness. R3 is 68 years assessed with a brief interview for mental status of 15 according to minimum data set assessment (MDS) dated [DATE]. Section gg (functional) of the same assessment documented that R3 is dependent on staff for Activities of daily Living (ADL) care needs. On 05/04/2026 10:45 AM, R3 was observed in her room, awake and alert, stated that she is doing okay. R3 has a personal refrigerator that is noted to be very dirty, inside the refrigerator was noted a gallon of 2% milk dated 4/25/2026 and 1 bottle of Mayonnaise dated 6/11/2024. On 05/04/2026 11:12 AM, this observation was presented to V18 (C.N.A) who said that staff only clean the refrigerator if the residents ask them to, V18 was informed that there are some expired items in resident's refrigerator but V18 did not say anything. 05/05/2026 9:44 AM and 5/6/2026 at 10:31AM, surveyor checked resident's refrigerator and the expired items remained in the refrigerator. R89 is 76 years, MD assessment dated [DATE] section C (cognitive) documented a BIMS score of 15, section gg (functional) of the same assessment documented that resident is dependent on staff for some ADL care needs. On 05/04/2026 at 10:50 AM, R89 was in bed, awake and alert, and stated that she is doing okay. R89 has a personal refrigerator that was noted with some dark liquid spilled at the bottom of the refrigerator, there was no thermometer noted inside the refrigerator. R89 said that staff come in and check their refrigerator occasionally. On 05/04/2026 11:12 AM, V18 (C.N.A) was observed putting a plate of carry-out food inside the refrigerator with the liquid spill inside. Surveyor presented this observation to V18 who still put the food inside the refrigerator and said she will come back to clean it later. V18 added that staff only clean the refrigerator if the residents ask them to. On 5/6/2026 at 2:40PM V2 (DON) said that nursing department is responsible for cleaning the personal refrigerators and making sure that expired food items are removed. V2 said that housekeeping does not want to do it because they said it is not part of their job, so the decision is still up in the air but at this time, nursing department is responsible. (continued on next page)		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Personal food storage-Room refrigerator policy (undated) documented in part: Residents may obtain and store a personal refrigerator in their rooms, according to facility policy. Housekeeping to ensure that fridge is cleaned and spoiled items are removed. Procedure: Housekeeping should be assigned to monitor individual room storage and refrigerator unit temperature as well as the disposal of food and beverages to ensure food safety. All refrigerator units should have an internal thermometer which should be monitored by housekeeping. Refrigerator units must maintain safe internal temperatures in accordance with state and federal guidelines, Housekeeping is responsible for keeping personal refrigerators clean. Record review of pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, in part, Your facility must provide equal access to quality care regardless of diagnosis. Your facility must be safe, clean, comfortable, and homelike.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview and record review, the facility failed to ensure that staff follow its medication administration policy by failing to obtain a physician order before administering medication (R67) and failed to ensure that the right dose of medication was administered to a resident (R204). These failures affected two (R67 and R204) of six residents reviewed for medication administration. Findings include: R67 is 69 years and has resided at the facility since 3/1/2026. Past medical history includes, but is not limited to acute posthemorrhagic anemia, melena, other abnormalities of gait, reduced mobility, major depressive disorder, type 2 diabetes, end stage renal disease, etc. On 05/05/2026 9:10AM, observed medication pass for R67 with V23 (LPN) who administered 2 tablets of Tylenol amongst other medications. Per medication reconciliation, R67 does not have a physician order for Tylenol. Review of active physician order as of 5/5/2026 for R67 did not show any order for Tylenol. Medication administration record for the month of May does not contain Tylenol for R67 and V23 did not sign anywhere in the record to indicate that resident received Tylenol. On 05/06/2026 10:38 AM, V23 (LPN) was observed again on the floor passing medication to residents. Surveyor asked V23 if a physician order is required for administration of Tylenol and she said yes. Surveyor asked V23 to check R67's physician order for Tylenol and she said, I don't see any, I thought she had an order for that. R204 is 54 years and has resided at the facility since 2025. Past medical history includes, but not limited to multiple sclerosis unspecified, abnormal posture, urinary tract infection, elevated white blood cell, neuromuscular dysfunction, etc. Physician order dated 7/15/2025 documented the following: MiraLAX Powder (Polyethylene Glycol 3350) Give 17 gram by mouth one time a day for constipation. On 5/5/2024 at 10:00AM, medication administration was observed for R204 with V48 (Registered Nurse). While preparing polyethylene glycol powder, V48 placed a medicine cup on the medication cart. With a black marker, V48 drew a line halfway between the 15ml (milliliter) line and the 20ml line. V48 then poured the powder directly from the bottle into the medicine cup. When asked how much powder was present in the medicine cup, V48 replied approximately 17, between the 15 and 20. The powder appeared to level off at the 17 ml mark on the cup. On 5/5/2026 at 450PM, V3 ADON (Assistant Director of Nursing) demonstrated the process of measuring a dose of polyethylene glycol powder. V3 removed the cap from the medicine bottle and verified the standard dose of 17gram in the computer. V3 then proceeded to use the cap to measure the powder, pouring to the indicated line which equals one 17-gram dose. V3 said, 'the medication cups don't provide an accurate measurement of 17 grams which is why the provided cap should be used to measure the exact dose. On 5/6/2026 at 2:40PM V2 (DON) said that the expectation for medication administration is that the nurses follow the five rights of medication administration, make sure medications are given according to physician order. V2 said that physician order is needed for administration of all medications including Tylenol. Medication administration policy revised 5/2025 documented the following: General: All medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis. Guideline: 1. An order is required for administration of all medications. 2. Medications are administered by licensed personnel only. 13. Verify that medication is being administered at the proper time, in the prescribed dose, and by the correct route. 14. Prepare and pour each dose of medication using an appropriate measuring device. Job description for Registered Nurse (RN) and Licensed Practical Nurse (LPN) (undated) states in part: Basic Function Under the direction of the physician, is responsible for total nursing care to all residents on assigned unit during the assigned shift including responsibility for delegation of duties, resident nursing care, staff performance and adherence by staff members to (continued on next page)		

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility policies and procedures.Essential Duties:3. Administer prescribed medications and treatments according to policy and procedures; evaluate treatment effectiveness on a continuing basis.8. Remain current in facility policies, procedures and nursing trends by participating in in service and continuing education programs.10. Document nursing care rendered, resident response, and all other pertinent and necessary data as outlined in facility's policies and procedures.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to have a five percent (5%) or lower medication error rate. There were two medication errors out of 31 medication opportunities resulting in a 6.45% medication error rate. This failure affected two (R67 and R204) of six residents reviewed for medication administration. Findings include: On 05/05/2026 9:10AM, observed medication pass for R67 with V23 (LPN) who administered 2 tablets of Tylenol amongst other medications. Per medication reconciliation, R67 does not have a physician order for Tylenol. R67 is 69 years and has resided at the facility since 3/1/2026. Past medical history includes, but is not limited to acute posthemorrhagic anemia, melena, other abnormalities of gait, reduced mobility, major depressive disorder, type 2 diabetes, end stage renal disease, etc. Minimum Data Set assessment dated [DATE] section C (cognitive patterns) documented a brief interview for mental status (BIMS) score of 15, section gg (functional) of the same assessment documented that R67 requires set up or clean up assistance, substantial/ maximal assistance, for some activities of daily living (ADL) needs and dependent on staff for others. Review of active physician order as of 5/5/2026 for R67 did not show any order for Tylenol. Medication administration record for the month of May does not contain Tylenol for R67 and V23 did not sign anywhere in the record to indicate that resident received Tylenol. On 05/06/2026 10:38 AM, V23 (LPN) was observed again on the floor passing medication to residents. Surveyor asked V23 if a physician order is required for administration of Tylenol and she said yes. Surveyor asked V23 to check R67's physician order for Tylenol and she said, I don't see any, I thought she had an order for that. On 5/6/2026 at 2:40PM V2 (DON) said that the expectation for medication administration is that the nurses follow the five rights of medication administration, make sure medications are given according to physician order. V2 said that physician order is needed for administration of all medications including Tylenol. R204 is 54 years and has resided at the facility since 2025. Past medical history includes, but not limited to multiple sclerosis unspecified, abnormal posture, urinary tract infection, elevated white blood cell, neuromuscular dysfunction, etc. MDS assessment dated [DATE] documented a BIMS score of 15, section gg of the same assessment documented that resident requires substantial/ partial moderate assistance for some ADL care needs and dependent on staff for others. Physician order dated 7/15/2025 documented the following: MiraLAX Powder (Polyethylene Glycol 3350) Give 17 gram by mouth one time a day for constipation. On 5/5/2024 at 10:00AM, medication administration was observed for R204 with V48 (Registered Nurse). While preparing polyethylene glycol powder, V48 placed a medicine cup on the medication cart. With a black marker, V48 drew a line halfway between the 15ml (milliliter) line and the 20ml line. V48 then poured the powder directly from the bottle into the medicine cup. When asked how much powder was present in the medicine cup, V48 replied approximately 17, between the 15 and 20. The powder appeared to level off at the 17 ml mark on the cup. On 5/5/2026 at 450PM, V3 ADON (Assistant Director of Nursing) demonstrated the process of measuring a dose of polyethylene glycol powder. V3 removed the cap from the medicine bottle and verified the standard dose of 17gram in the computer. V3 then proceeded to use the cap to measure the powder, pouring to the indicated line which equals one 17-gram dose. V3 said, 'the medication cups don't provide an accurate measurement of 17 grams which is why the provided cap should be used to measure the exact dose. Medication administration policy revised 5/2025 documented the following: General: All medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis. Guideline: 1. An order is required for administration of all (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications.2. Medications are administered by licensed personnel only.13. Verify that medication is being administered at the proper time, in the prescribed dose, and by the correct route.14. Prepare and pour each dose of medication using an appropriate measuring device.		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on interview and record review, the facility failed to obtain routine dental services for one resident with an order for a dental consultation. This affected one of one resident (R5) in a total sample of 38 residents reviewed for dental services. R5's face sheet documents an admission date of 05/17/2025 with diagnoses that include but are not limited to malignant neoplasm of laryngeal cartilage, acquired absence of larynx, tracheostomy care, aphonia, and dysphagia. R5's BIMS (brief interview for mental status) score, dated 10/01/2025, was 13 which indicates R5 is cognitively intact. On 05/05/2026 at 9:00 AM, R5 had a tracheostomy and limited ability to speak but was able to communicate by whispering short answers and nonverbally by hand gestures and head nodding. R5 whispered no and indicated by side-to-side head movement that R5 has not seen a dentist in the past 4 months. Review of R5's clinical record indicates a physician order for dental consultation dated 04/02/2026 at 8:43 AM. On 05/06/2026 at 9:15 AM, V5 (Social Services Director) stated that social services are responsible for adding residents to the list for dental evaluations after physician orders are received and they are notified by nursing. V5 (Social Services Director) stated R5 should have been added to the list and seen on 04/30/2026. The dentist will also ask on the day of the visit if there are additional residents that need be added or seen during the monthly visit. V5 (Social Services Director) reviewed the list of residents for dental evaluations and affirmed R5 was not on the list of residents for dental evaluations by the facilities' dental contracted service on 04/30/2026 nor on the reports of residents seen. R5's Nursing Care Plan dated 08/03/2025 indicates R5 is at risk for oral/dental problems with interventions documented in part coordinate arrangements for dental care, transportation as needed/as ordered. On 05/06/2026 at 4:45 PM V2 (Director of Nursing) stated the facility policy for dental consultations is social services will add residents to the monthly list after notification by nursing. Review of the facility's Dental Services policy dated 01/2026 documents in part to provide dental services to our residents. Record review of pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, in part, Your facility must provide services to keep your physical and mental health, at their highest practical levels.		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview and record review, the facility failed to provide a call light for residents to call for assistance and failed to make sure the call light was in good repair. These failures affected two residents (R197 and R179) reviewed in a sample of 63 residents. Findings include: R179's minimum data set (MDS) (dated 3/31/2026) documents a brief interview of mental status summary score of 15, indicating R197 is cognitively intact. The MDS documents the following diagnoses: cancer, malnutrition, inguinal hernia, disturbances of salivary secretion, opioid use, other post-procedural pain. R179 requires supervision/touching assistance with activities of daily living. R197's minimum data set (2/28/2026) documents the following A) a brief interview of mental status summary score of 15, indicating R179 is cognitively intact. B) following diagnoses: pathological fracture of right humerus, cancer, anemia, hypertension, orthostatic hypotension, diabetes mellitus, hyperlipidemia, hip fracture, chronic pain syndrome, muscle wasting and atrophy, unsteadiness on feet. C) Impairment on one side of upper and lower body, partial/moderate assistance for toileting, supervision/touching assistance for bed mobility, dependent on staff for bed to chair transfers, dependent on staff for toileting assistance and utilizes a wheelchair. On 5/4/2026 at 10:40 AM, observed no call light available for R197 and R179 to call for staff assistance. The call light jack near R179 and R197's beds was hanging with a left tilt (not flush, hanging from wall) and not in working condition. There were no call light cords plugged into the jack. R179 and R197 were in their bed. R179 and R197 confirmed they did not have a call light to call for assistance and would have to get their roommate across the room to call for assistance. No bell or alternate form of call light observed within the resident's reach. On 5/5/2026 at 12:21 PM, V8 (Maintenance Director) acknowledged that there was no call light available for R197 and R179 to use. V8 explained the call lights had been missing for at least two weeks. V8 affirmed that all of the resident rooms should be equipped with functioning call lights and would provide manual bells to R197 and R179 to use. V8 said the facility received a work order quote to repair the entire call light system on the 3rd floor, however, no work had begun nor was it scheduled. V8 provided a written quote dated 4/22/2026 and included replacing call lights in the third-floor resident rooms and in the shower room. There is no indication the quote was approved or when the repairs would be completed. The quote was not signed. Facility preventative maintenance policy (1/1/2026) documents, A Preventative Maintenance Program shall be developed and implemented to ensure the provision of a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. 1. The Maintenance Director is responsible for developing and maintaining a schedule of maintenance services to ensure that the buildings, grounds, and equipment are maintained in a safe and operable manner.		

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F 0607 Level of Harm - Potential for minimal harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement their abuse policy, failed to implement coordination with the QAPI program as indicated in the abuse policy, failed to implement and post a notice in a conspicuous location informing covered individuals of their rights including the right to file a complaint with the State Survey Agency, failed to post a notice informing covered individuals of their rights in a size that was no less than the minimum required for other employment-related signs. This failure has the potential to affect all 200 residents that reside in the facility. Findings include: Facility census (5/4/2026) documents 200 residents reside in the facility. R202's face sheet documents in part R202 is a [AGE] year-old resident with diagnoses including: displaced fracture of 3rd metatarsal bone right foot, type 2 diabetes mellitus with diabetic neuropathy, major depressive disorder, wedge compression fracture of 4th vertebrae, unspecified muscle wasting and atrophy, personal history of transient ischemic and dysphagia. R202's minimum data set (4/7/2026) documents in part a brief interview of mental status (BIMS) summary score of 15, indicating R202 is cognitively intact. On 5/4/2026 at 11:35 AM, R202 stated the care here is not good. Not good at all. I'm trying to transfer out of here to another facility. You can complain about things, but nothing changes. I don't think people like to say anything, like they are afraid to talk about it. I don't know where the number to notify you guys (state survey agency) is. I think people have called, but I haven't seen it posted anywhere. R6's face sheet documents the following diagnoses: end stage renal disease, muscle wasting and atrophy, urinary tract infection, quadriplegia, metabolic encephalopathy, anemia, dysarthria following cerebrovascular disease R6's minimum data set (3/27/2026) documents a brief interview of mental status summary score of 15, indicating R6 is cognitively intact. Additionally, the minimum data set documents R6's is dependent on staff for activities of daily living. On 5/4/2026 at 11:42 PM, R6 explained that R6 was handled roughly often by staff while turning/repositioning on evening shifts. R6 did not want to tell the surveyors which staff member handled R6 roughly due to fears they would do something to (R6) (retaliate). R6 was displaying signs of anxiety, including increased respirations, restlessness. R6 later described and identified V66 (Certified Nursing Assistant) as the staff member. R6 reiterated, I don't want them to do nothing to me (retaliate against R6). On 5/5/2025 at 1:50 PM, V1 (Administrator) affirmed V1 is the abuse prevention coordinator for the facility. V1 affirmed the posting for covered individuals of their rights to file a complaint with the state survey agency was posted in the elevator and on the units. A facility tour was completed with V1 of all floors, resident units, nurse's stations, bulletin boards, nurse's stations, elevators, reception areas, facility main entrance, employee break rooms, employee time clock areas and did not observe any notice posted in a location that informed covered individuals of their rights under 1150B and the right to file a complaint with the state survey agency if they believe the state survey agency retaliated against an employee for reporting. The elevator bulletin boards were covered in a glass casing to allow access for only staff. V1 confirmed these observations and confirmed that there was no posting that met the regulatory requirements within the facility. V1 did not know why the posting was not posted. V1 stated, I think HR would know, maybe HR moved it. On 5/5/2025 at 2:05 PM, observed V58 (Licensed Practical Nurse) and V59 (Licensed Practical Nurse) sitting at the 2nd floor nurse's station during the tour. V58 stated I thought I saw a posting like that around here somewhere, but I don't know where. I do have the legal responsibility to report a crime. V58 and V59 denied observing any postings while at the nurse's station. On 5/5/2025 at 2:27 PM, V61 (HR Director) stated, It (the posting) was on my (office) door. Observed V61's office (continued on next page)		

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F 0607 Level of Harm - Potential for minimal harm Residents Affected - Many	door with V1 (Administrator) and V61 and the posting was not on the door. V1 and V61 confirmed this observation. V61 stated, I don't know where I moved it to, I think I took it down (from my door), I don't know where it is. On 5/5/2025 at 3:49 PM, V65 (Family Member) explained V65 wanted to talk to the state survey agency about the care received in the building. V65 did not want to disclose what the family member's name was for fear of retaliation. On 5/6/2025 at 10:35 AM, observed a typed sign on 8.5x11 bright green paper taped to the front desk indicating covered individuals of the rights to report a crime and a typed sign on 8.5x11 bright blue paper for section 1150 B mandatory reporting requirements. V57 (Receptionist) observed the postings and confirmed that the postings were not in place yesterday. V57 stated staff placed the signs last night. On 5/6/2026 at 10:40 AM, reviewed QAPI (Quality Assurance Performance Improvement) program and QAPI program data collection with V1 (Administrator). Abuse data, including but not limited to, accident reports, incident reports, missing item reports, safety committee reports, allegations of abuse were last collected and reviewed by the QAPI committee on 1/30/2026. On 4/30/2026, the meeting minutes and data were reviewed, and no indication of accident reports, incident reports, concern reports or abuse/neglect allegations were reviewed with the QAPI program for the quarter. V1 affirmed there was no other QAPI committee meetings between 1/30/2026 and 4/30/2026. V1 reviewed the meeting minutes and agenda for 4/30/2026 and affirmed the required abuse-related data was not reviewed by the QAPI committee during the quarterly meeting. V1 stated, I did go over it, but I don't think I wrote it down. V1 affirmed there is no documentation to verify that the QAPI committee discussed abuse allegations, or other requisite information as indicated in the abuse policy. V1 reviewed the abuse policy and affirmed abuse data should be tracked and a notice of covered individuals rights should be posted. No further documentation was provided to the survey team that indicates the required data was collected or reviewed as indicated in the abuse policy prior to the exit of the survey. V1 affirmed there was approximately 2 reportable abuse allegations per month in the quarter between 1/30/2026-4/30/2026. On 5/6/2026 at 11:30 AM, On 5/6/2026 at 11:30 PM, V55 (Chief Operating Officer) affirmed V55, V56 (Chief Clinical Officer) and V50 (Vice President of Clinical Operations) serve as the governing body for the facility. V55 affirmed the governing body is responsible for the development and implementation of policies in the facility. V55 explained the facility had recently undergone a change of ownership on 3/1/2026 and the new governing body started overseeing on 3/1/2026. When the change of ownership occurred, the facility staff were in-serviced on all of the new ownership's policies. V55 and V56 affirmed V55 and V56 did not attend the QAPI meeting on 4/30/2025 but was updated on the data collected by the committee via phone. V55 recalled addressing other concerns from the QAPI meeting (redacted- unrelated to abuse data collection). V56 affirmed V55 encourages V1 to make action plans for any quality improvement needed areas. V55/V56 unaware of any concerns of residents or family members that were afraid of retaliation. V55/V56 reviewed the QAPI data collected on 4/30/2026 and affirmed there was no documentation indicating abuse related data was collected/reviewed with the QAPI committee. V55 affirmed V55 regularly visits the facility weekly and V50 visits weekly and were not aware the requisite postings for covered individuals' rights for reporting crimes were not posted. V56 explained the posting is important because if someone is scared to report things, they might be scared to lose their jobs, but then they may not report as required. V56 affirmed when the change of ownership occurred, the parent company sent the signs to the facility to be posted. V56 was unsure why the signs were not posted. On 5/6/2026 at 1:37 PM, V6 (Activity Director) affirmed V6 is a part of the QAPI committee. V6 affirmed that abuse is something that is regularly discussed in the QAPI meeting. V6 stated that the required notice informing covered individual's rights is posted in the breakroom. V6 denied observing the notice in the breakroom prior to yesterday. V6 explained the (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145718	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2026
NAME OF PROVIDER OR SUPPLIER Thryve of Crestwood		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0607 Level of Harm - Potential for minimal harm Residents Affected - Many	posting is important because you want to make sure staff and residents do not get retaliated against if they report any concerns. I (V6) always tell my staff to report anything that may be an issue. On 5/6/2026 at 3:36 PM, observed the typed signs on the front desk with V1 and V57. V1 and V57 affirmed that the sign was printed on 8.5x11 paper. V1 and V57 were unsure what the size requirements of the notices were to be. At 3:40 PM, observed the postings with V56 (Chief Clinical Officer). V56 was unsure the size requirements of the notice. On 5/6/2026 at 2:13 PM, V5 (Social Services Director) affirmed V5 was part of the QAPI committee. V5 denied any knowledge of any other QAPI committee meeting between 1/30/2026 and 4/30/2026. V5 recalled the last QAPI meeting was on 4/30/2026 and affirmed abuse and incidents are something that is reviewed during the QAPI meeting. V5 reviewed the meeting minutes for 4/30/2026 and affirmed the meeting minutes did not confirm any abuse-related data was collected regarding allegations, incident reports, safety committee meeting reports, etc. V5 could not recall if this data was reviewed in the last QAPI meeting. V5 was unsure if a posting informing covered individuals of their rights and the right to complain to the state survey agency was posted. V5 stated, I know we have things like the identified offender posting, but I don't know if there is anything posted about covered employee's rights regarding filing complaints about retaliation. V5 explained it is important for staff (covered individuals) to know their rights and know they can't be retaliated against for reporting. It is important they (staff) know so they will feel comfortable reporting abuse and criminal acts. If we don't know if anything is wrong, we can't keep the residents safe if staff are afraid of retaliation. On 5/6/2026 at 5:00 PM, V1 (Administrator) affirmed the facility should be following the facility's policies and procedures. V1 affirmed there are size requirements for employee-related signs. V1 affirmed V1 had sent the signs off to be printed off by another company in larger paper. V1 affirmed covered individuals need to know they will be free from retaliation/have the right to complaint to the state survey agency. V1 affirmed the posting is important so that staff will feel comfortable with reporting. Review of Occupational Safety and Health Administration standard 1903.2 - Posting of notice; availability of the Act, regulations and applicable standards, documents. Each employer shall post and keep posted a notice or notices, to be furnished by the Occupational Safety and Health Administration, U.S. Department of Labor, informing employees of the protections and obligations provided for in the Act, and that for assistance and information, including copies of the Act and of specific safety and health standards, employees should contact the employer or the nearest office of the Department of Labor. Such notice or notices shall be posted by the employer in each establishment in a conspicuous place or places where notices to employees are customarily posted. Each employer shall take steps to insure that such notices are not altered, defaced, or covered by other material. Reproductions or facsimiles of such Federal or State posters shall constitute compliance with the posting requirements of section 8(c)(1) of the Act where such reproductions or facsimiles are at least 8 1/2 inches by 14 inches, and the printing size is at least 10 pt. Whenever the size of the poster increases, the size of the print shall also increase accordingly. The caption or heading on the poster shall be in large type, generally not less than 36 pt. Facility QAPI policy (1/2026) documents in part, It is the policy of this facility to develop, implement and maintain an effective comprehensive data-driven QAPI program that focuses on indicators of the outcomes of care quality of life and addresses all the care and unique services the facility provides. Quality Assurance and Performance Improvement (QAPI) refers to the coordinated application of two mutually reinforcing aspects of a quality management system: (QA) and Performance Improvement (PI). QAPI takes a systemic, interdisciplinary, comprehensive, and data driven approach to maintaining and improving safety and quality in nursing homes, while involving residents and families in practical and creative (continued on next page)		

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F 0607 Level of Harm - Potential for minimal harm Residents Affected - Many	problem solving . 4. The facility will maintain documentation and demonstrate evidence of its ongoing QAPI program. Documentation may include, but is not limited to: a. the written QAPI plan. b. Systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events. c. data collection and analysis at regular intervals d. Documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities. 5. The plan and supporting documentation will be presented to the State Survey Agency or Federal Surveyor at each annual survey and upon request . 2. Governance and Leadership -- a. The governing body and/or executive leadership is responsible and accountable for the QAPI program . 3. Program feedback and monitoring -- a. The facility maintains procedures for feedback, data collection systems, and monitoring, including adverse event monitoring. b. the facility draws data from multiple sources including input from all staff, residents, families and others as appropriate. Data sources may include, but are not limited to: . viii. Incident and accident reports, including reports of adverse events or abuse, neglect or exploitation, Facility abuse policy (10/2025) documents in part, ABUSE POLICY This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. This will be done by: .orienting and training employees on how to deal with stress and difficult situations, and how to recognize and report occurrences of abuse neglect, exploitation, and misappropriation of property; establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment; identifying occurrences and patterns of potential mistreatment' . A notice will be posted stating an employees' and covered persons' obligation for reporting a suspected crime and how to file such a report without retaliation . IX. QAPI Pattern Assessment: At least quarterly, the Quality Management committee will review concern identification reports, accident reports, incidents reports, missing items reports, and safety committee reports to assess possible patterns or trends of suspicious bruising of residents, unexplained accidents, or other unusual occurrences that may constitute abuse, neglect, mistreatment or misappropriation of resident property. Based on an assessment of the reports, the Quality Management committee will further investigate and/or determine whether a change in facility practices is warranted. Quality Management Review: Any investigation that concluded that abuse, neglect, exploitation, mistreatment or misappropriation of resident property occurred shall be reviewed by the facility Quality Management committee for possible changes in facility practices to ensure that similar events do not occur again. The investigation shall be reviewed at the next quarterly Quality Management committee meeting, or sooner if possible. 1. Facility will include Abuse, Neglect and Exploitation allegations into the facility's QAPI program and substantiated incidents will immediately be reviewed and included in the facility's QAPI program. 2. Assessing these incidents within the QAPI / QA committee work may lead to areas that require additional training and/ or additional supervision. 3. The QA Committee will have a quarterly summary of these incidents for review at their meeting .		