STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146192	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thrive of Lisle	2850 Ogden Avenue Lisle, IL 60532

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39543 Based on observation, interview, and record review the facility failed to ensure daily weights were completed for residents with congestive heart failure (R39) and failed to ensure residents with vascular wounds had offloading devices in place (R139, R140). This applies to 3 of 10 residents (R39, R139, R140) reviewed for congestive heart failure, and non-pressure wounds in the sample of 20. The findings include: 1. R39's Admission Record (Face Sheet) showed an admitted [DATE] with a diagnosis of congestive heart failure (CHF, weakened heart condition). R39's 12/12/24 Minimum Data Set showed he was cognitively intact. R39's January 2025 Medication Administration Record (MAR) showed an order for daily weights beginning on 1/12/25. R39's Electronic Health Record/weights and MAR showed daily weights were not documented as being done (as of 1/30/25) on 1/16/25, 1/24/25, 1/25/25, and 1/26/25. On 1/30/25 at 12:03 PM, R39 said, I've never refused to be weighed. I try not to cause a fuss and just go along with what they want. I'm not sure why monitoring my weight is important, but I do retain fluid. On 1/30/25 12:20 PM, V2 (Director of Nursing/DON) stated daily weights are ordered for CHF residents due to their risk of retaining fluid. V2 said the retained fluid can lead to breathing and heart problems, which can lead to possible hospitalization . V2 said if there is weight gain above a set amount, the provider is notified, and diuretics can be ordered or adjusted; potentially keeping the resident from being hospitalized . The facility's Weight Policy (revision 11/2024) showed CHF residents will be weight twice weekly .unless otherwise ordered by the physician. 20042 (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 1/28/25 at 10:39 AM, R139 was in bed on his back with the head of his bed elevated. R139 had a dressing to his left foot. R139's heels were resting on his mattress. R139 had an offloading boot laying in a chair at his bedside. At 10:45 AM, V9 (R139's family) walked into R139's room, saw the offloading boot in the chair and stated it was supposed to be on R139. V9 stated R139 has diabetes, poor circulation, stubbed his big toe on his left foot which snowballed everything. V9 stated R139 developed an infection and gangrene to his toes that they were managing at home for the past year. R139 had seen podiatry and wound care. V9 stated last Tuesday (1/21/25) R139 saw a vascular surgeon and R139 did not have any blood flow to his left foot. R139 had an angiogram done the next day and it was determined that R139 would need to have part of his foot and toes removed. V9 stated R139 is supposed to have the off loading boot in place to his left foot. On 1/29/25 at 2:05 PM, V2 (DON) stated R139 should have the boot on his foot. He just had surgery to his foot and is at high risk for breakdown. On 1/29/25 at 2:25 PM, V15 LPN (Licensed Practical Nurse/Wound Nurse) stated R139 should have the off loading boot on to relieve pressure. V15 stated R139 came from the hospital with the boot for his left foot. The Face Sheet dated 1/29/25 for R139 showed medical diagnoses including cellulitis of left lower limb, type 2 diabetes mellitus, gangrene, peripheral vascular disease, hypertension, hypothyroidism, weakness, difficulty walking, unspecified convulsions, congestive heart failure, and atrial fibrillation. The Skin/Wound Note dated 1/27/25 at 2:38 PM for R139 showed, wife present with guest and requesting amputation site to be open to air when in bed with heel boot protectors on and cover with rolled gauze when up in the wheelchair to protect amputation site; updated treatment. The Psychiatry Progress Note dated 1/27/25 at 9:36 AM for R139 showed, Chief complaint: Impaired mobility and ADL (activities of daily living) secondary to neuromuscular deconditioning and gait instability due to left lower extremity cellulitis and status post left TMA (transmetatarsal amputation). History of present illness: Patient is an [AGE] year old male with a past medical history (see below) who was admitted to the extended care facility for skilled nursing and rehabilitation secondary to deficits in mobility and ADLs. R139 was admitted into the hospital due to gangrenous change of the digits in his left lower extremity. R139 is status post left foot TMA. Alert and oriented x 3 (person, place, and time). Calm and cooperative with examination. Assessment/Plan: Impaired mobility and ADL dysfunction secondary to neuromuscular deconditioning and gait instability due to left lower extremity cellulitis and status post left TMA. Deconditioning/Gait instability: R139 is high risk for functional impairment without therapy and adequate pain control. R139 has a high risk for developing contractures, pressure ulcers, poor healing if not receiving adequate therapy and pain control. Increased risk for pressure injuries. Continue pressure injury prevention protocol. Wound care services to follow as indicated. The Physician Orders dated 1/27/25 for R139 showed pressure redistribution mattress and cushion as indicated; Encourage guest to float heels while in bed. The Care Plan dated 1/25/25 for R139 showed he has actual impairment to skin integrity related to fragile skin, limited mobility, and surgical wound. Surgical (wound) to left (foot) toes; left dorsal foot. Vascular wound to left heel. Ensure that heels are elevated while resident is lying in bed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Skin/Wound Note dated 1/26/25 at 10:07 PM showed, Skin assessment for admission completed, noted bilateral arms with bruise; right heel with redness; sacrum with redness; left dorsal foot with, and left toes amputations with surgical incision; left heel with vascular/callous. See order for treatment under order. The facility's Skin Integrity policy (11/2019) showed, General: to ensure the resident's skin is assessed and interventions implemented to promote the prevention of wounds and other associated skin problems, Procedure: The licensed nurse and interdisciplinary team will assess and periodically reassess each resident's risk for developing pressure and take action to address any identified risks. The interdisciplinary team will create a written plan for the identification of risk for and prevention of pressure ulcers. If the resident is determined to be at risk or has developed any skin integrity abnormalities, the nurse will implement action according to the specific skin tissue identified per protocol including but not limited to: Protecting against adverse effects of external mechanical forces. The interdisciplinary team, including the physician will create a written plan for the treatment of impaired skin integrity which will be included in the resident's individualized plan of care. Ensure positioning avoids pressure on any existing pressure areas. 3. The Skin/Wound Note dated 1/29/25 at 9:29 AM for R140 showed, guest was seen by wound MD . continue previous treatment to both heels every other day .reinforce education to reposition as tolerated, float heels .guest totally dependent of care. The Physician Orders Summary dated 1/29/25 for R140 showed an order dated 1/14/25 to have heel protectors on while in bed and off when he is up. On 1/28/25 at 10:29 AM, R140 was in bed on his back with the head of his bed elevated. R140 did not have any offloading measures in place to his heels. R140's heels were resting on his bed. On 1/29/25 at 11:36 AM, V6 CNA (Certified Nursing Assistant) and V7 CNA stated sometimes the nurse tells them they can put a pillow under a resident's legs to keep heels up. V6 and V7 stated it is also in the charting who is supposed to have their heels up off the bed. V6 and V7 stated it was important for resident's heels to be elevated off the bed because they don't want sores and to decrease swelling. The Skin/Wound Note dated 1/22/25 at 2:33 PM for R140 showed, Guest was seen by wound physician . bilateral heels blister and discoloration. Nursing order - betadine and cover with hydrocolloid dressing daily. All orders will be carried out. Reinforce education to continue to reposition and float heels. The Wound Round Note dated 1/14/25 for R140 showed, left heel vascular wound, blood filled blister; right heel vascular wound, nonblanchable erythema present. The Progress Notes for R140 dated 1/13/25 through 1/30/25 did not show any refusal of off loading his heels in bed. The Care Plan dated 1/13/25 for R140 showed, R140 has impaired skin integrity with increased risk for additional skin breakdown related to decreased mobility, poor tissue perfusion, diabetes mellitus, polyneuropathy, vascular disease, and alcohol dependence with cirrhosis. Ensure that heels are elevated while resident is lying in bed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Skin Integrity policy (11/2019) showed, General: to ensure the resident's skin is assessed and interventions implemented to promote the prevention of wounds and other associated skin problems, Procedure: The licensed nurse and interdisciplinary team will assess and periodically reassess each resident's risk for developing pressure and take action to address any identified risks. The interdisciplinary team will create a written plan for the identification of risk for and prevention of pressure ulcers. If the resident is determined to be at risk or has developed any skin integrity abnormalities, the nurse will implement action according to the specific skin tissue identified per protocol including but not limited to: Protecting against adverse effects of external mechanical forces. The interdisciplinary team, including the physician will create a written plan for the treatment of impaired skin integrity which will be included in the resident's individualized plan of care. Ensure positioning avoids pressure on any existing pressure areas.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 20042 Based on observation, interview, and record review the facility failed to ensure an indwelling urinary drainage bag was not laying on a bed or residents lap during a transfer, and catheter tubing was not laying on the floor for 1 of 4 residents (R140) reviewed for catheters in the sample of 20. The findings include: On 1/28/25 at 10:29 AM, R140 was laying on his back in bed with the head of his bed elevated. R140 had an indwelling urinary catheter drainage bag laying on his bed next to his right foot. On 1/28/25 at 10:56 AM, R140 was sitting up in bed wearing a gray shirt, gray pants and grip socks. R140's indwelling urinary catheter drainage bag was laying on his lap. V5 CNA (Certified Nursing Assistant) and V6 CNA went into R140's room with a full mechanical lift and transferred R140 from his bed to his wheelchair with the drainage bag on his lap. V5 stated she had the drainage bag on R140's belly because she was getting ready to transfer him. V5 and V6 stated the drainage bag should be kept on the side of the bed and below his bladder. V6 stated the drainage bag should be kept below his bladder so it can drain and so urine doesn't go backwards. On 1/28/25 at 12:10 PM, R140 was sitting in his wheelchair in the dining room at the dining room table. R140's catheter tubing was laying on the floor under his wheelchair. On 1/29/25 at 11:18 AM, V8 LPN (Licensed Practical Nurse) stated R140's drainage bag should be below the level of his bladder and not on his bed. V8 stated the drainage bag should be on the lower side of the bed or under his chair when he is up. V8 stated this is to keep the urine from going backward. V8 stated the drainage bag cannot be on the bed because that is something to do with infection. V8 stated the drainage bag should not be on his lap during a transfer with the mechanical lift. V8 stated there are two people to do the transfer and one person should be holding onto the resident and one should be holding the drainage bag. V8 stated catheter tubing should not be on the floor for infection reasons and it could come out or get damaged when R140 is being pushed in his wheelchair. The Face Sheet dated 1/29/25 for R140 showed diagnoses including alcoholic cirrhosis of the liver, gastrointestinal hemorrhage, acute kidney failure, thrombocytopenia, type 2 diabetes mellitus, alcohol dependence, congestive heart failure, benign prostatic hyperplasia, obstructive and reflux uropathy, and hypertension. The Care Plan dated 1/13/25 for R140 showed, R140 has a urinary catheter. Check placement of tubing each shift. The Catheterization of Urinary Bladder policy (11/2018) showed, hang collection bag appropriately to the side of bed, keeping below the bladder and off the floor.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45395 Based on observation, interview, and record review the facility failed to implement their intravenous catheter care policy and procedures for a resident (R2) with a midline catheter in place. This applies to 1 of 1 residents (R2) reviewed for intravenous catheters in the sample of 20. The findings include: R2's face sheet indicated that R2 was last admitted to the facility on [DATE] and has a past medical history not limited to: urinary tract infection, chronic kidney disease stage 3, need for assistance with personal care, hypo/hypertension, polyneuropathy, and abnormal findings of blood chemistry. Review of R2's Brief Interview for Mental Status (BIMS) evaluation dated 01/18/2025 documented score of 13.0 intact cognitive response. On 01/28/2025 at 10:33 AM, R2 was observed lying in bed and stated that she has been at this facility for about three weeks. Surveyor observed an intravenous (IV) line inserted to her left upper arm that had dried blood to the circular pad surrounding the insertion site which were all covered with an undated transparent dressing and secured to R2's skin with white medical tape. Surveyor also observed an intravenous pole next to the bed with an empty bag of intravenous medication (ertapenem sodium solution 1 gram) hung from the pole but was not connected to R2's intravenous line. R2 said she receives an antibiotic through the line but could not recall when she last received a dose because she was unsure about the administration times. R2 also said that she could not recall when the intravenous line was inserted or when the dressing was last changed. Review of R2's vascular access device insertion consent form signed on 01/26/2025 documented that a single lumen (SL) midline was inserted to resident's left cephalic vein with internal catheter length of 15 centimeters (cm) and arm circumference of 40 cm. Review of R2's progress notes showed a health status nurses note dated 01/27/2025 at 00:11 (12:11 AM) which documented, Midline inserted by PICC [peripherally inserted central catheter] team to left upper arm. To start IV Ertapenem 1 gm tomorrow for 5 days . Review of R2's active orders as of 01/28/2025 showed the following: may insert midline, order date 01/26/2025; ertapenem sodium solution reconstituted use 1 gram (GM) intravenously one time a day for urinary tract infection (UTI) for 5 days. If Midline is placed sooner, change antibiotic (ABT) to start as soon as possible (ASAP), start date 01/27/2025 and end date 02/01/2025. No orders for intravenous line care and/or maintenance were indicated. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/29/2025, review of R2's care plan with date initiated 01/28/2025 reads in part: has midline inserted related to IV antibiotic use thru 02/01 with Interventions to: observe IV dressing every shift. change dressing and record observations of site weekly; IV flushes per physician's orders; monitor/document/report as needed (PRN) signs/symptoms of infection at the site: drainage, inflammation, swelling, redness, warmth; monitor/document/report as needed (PRN) signs/symptoms of leaking at the IV site: edema at the insertion site, taut, shiny or stretched skin, whitening/blanching or coolness of the skin, slowing or stopping of the infusion, leaking of IV fluid out of the insertion site all with documented date initiated of 01/28/2025 on page 14 of 19. On 01/29/2025 at 10:17 AM, observed a new dressing was now applied to R2's left upper arm that was not the dressing observed by surveyor on 01/28/2025 and dressing was now dated 01/29/2025. Initials on this dressing were not legible. Review of R2's electronic medication and treatment records showed no documentation of when the dressing was changed, and no progress note was found documenting that the dressing was changed or being monitored for signs of infection. On 01/30/2025 at 09:21 AM, observed R2 lying in bed eating breakfast. No midline was observed to R2's left upper arm at this time, and IV pole was not observed next to the bed as previous. R2 said oh they must have taken it out, they don't tell me anything. No evidence of resident pulling out her midline or removing the dressing was observed to the bed or floor, and no bleeding was observed at the insertion site. On 01/30/2025 at 09:37 AM, V12 (Registered Nurse/RN) said he received in report by the previous shift that R2 had a midline in place to her left upper arm and is receiving IV antibiotics daily until 02/01/2025. At 09:40 AM, surveyor entered R2's room with V12 (RN) and upon V12's assessment of R2, V12 said that he was unsure as to why resident's midline was no longer in place, who had removed it or when it was removed. On 01/30/2025 09:50 AM, V2 (Director of Nursing/DON) said when a peripherally inserted central catheter (PICC) or midline is inserted, an outside PICC team performs the procedure then places a dressing to cover the site. V2 then said the dressing should be dated to indicate when it was done, and the nurse on duty should document procedure then input the orders for line maintenance/care such as monitor site and dressing every shift, change dressing weekly, etc. V3 (Infection Preventionist/IP) is supposed to then verify that the orders were inputted, and they are correct. Review of R2's electronic medication administration record (page 4 of 26) documented as of 01/30/2025 at 10:08 AM, resident received ertapenem sodium solution reconstituted 1 gram intravenously through her midline on 01/27 through 01/29/2025. No record found for intravenous line care, maintenance or monitoring of the insertion site were documented on R2's administration record. On 01/30/2025 at 10:15 AM, V12 (RN) said he placed a call to the Infectious Disease Nurse Practitioner (IDNP) regarding R2's midline being removed and for any new medication orders. V12 then said that an outside source is used to insert PICC/Midlines, consent form is signed prior to insertion, then the nurse or V3 (IP) enters the standing orders that include to monitor site and dressing for signs of infection every shift, weekly dressing changes, etc. V12 added that when a line is discontinued, it should be documented in a progress note in the resident's record. On 01/30/2025 at 10:39 AM, review of R2's progress notes now showed the following progress notes: (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Health Status Note (nurses note) dated 01/30/2025 at 10:11 AM that documented, [Infectious Disease Nurse Practitioner] here, came and reviewed urine result with order to [discontinue] ertapenem and midline order, colonized. Physician/PA/NP (Physicians Assistant/Nurse Practitioner) Progress Note (Narrative) dated 1/30/2025 at 08:16 AM that documented, . During assessment today on 01/30/25 patient continue to report asymptomatic status [with] new order to [discontinue] the IV [antibiotic] therapy all-together . Plan of care discussed with patient and nursing team [with] agreement & informed team to update if any change happens. Note was created on 01/30/2025 at 10:23:23 AM. On 01/30/2025 10:57 AM, V2 (DON) said R2 has no current orders for nursing to monitor site/dressing or for maintenance of her midline but may have been discontinued since the line is out and will review discontinued orders as well. V2 then said that she must also do some investigating as to what happened with the midline for R2. On 01/30/2025 at 11:16 AM, V2 said no discontinued orders were found for R2's midline care, and there should have been orders in place after the line was inserted by the nurse who was working (V13). V2 added that there should be documentation of when the midline was discontinued and that her investigation as to who discontinued R2's midline and when it was discontinued remained ongoing. On 01/30/2025 at 11:48 AM, V13 (RN) said that she was working at the time of R2's midline insertion but she forgot to enter the orders. V13 added that nursing usually enter orders to check patency of the line, monitor for signs/symptoms of infection, change the dressing weekly, flush with normal saline before/after antibiotic administration, monitor dressing and site every shift and to call physician with any findings. V13 then said these orders are entered for resident safety, to ensure PICC/midline care is being done, and to prevent infection with early detection. V13 also said that nursing are to document a progress note regarding the insertion of a line, when the dressing is changed, and when the line is discontinued. V13 added that when a line is discontinued, we need to have an order to discontinue, then measure the length of line and check if line tip is intact because if the tip is not intact, we are to order an x-ray then document any findings when the line was discontinued. On 01/30/2025 at 02:30 PM, facility provided a care plan for R2 that did not include documentation regarding resident's midline and/or the care of her line and active physician's orders that included x-ray to left upper arm to make sure it is free from any parts of a line. At 02:33 PM, V2 said the x-ray was ordered because it remains unknown who removed R2's midline and when. On 01/30/2025 at 2:57 PM, V1 (Administrator) provided the following orders that are inputed when an intravenous line is inserted: change dressing and needle-less access device every seven days and PRN (as needed), observe signs and symptoms of infection every shift, measure external catheter length every seven days, measure upper arm circumference every seven days, flush with normal saline before and after antibiotic treatment. Review of Central Line Care policy last revised/reviewed 04/2023 reads in part: General: To ensure the care and management of central venous access devices in accordance with all state and federal guidelines. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy: Peripherally inserted central catheter (PICC) line care dressing change, maintenance and removal will be completed according to standard of practice by licensed nurses only . Procedure: General instructions after insertion: all PICC lines treatments and dressings require a physician order. Only an RN trained in removal of a PICC line may remove a PICC line with a physician's order. Following the initial 24 dressing change an RN or LPN will change the injection cap and dressing at minimum weekly or any time the dressing becomes moist, loosened or soiled. Flushing a PICC line with saline and/or heparin and changing PICC line dressing: Gather all supplies and always maintain clean field. Wash hands: a PICC line must remain sterile; use soap and water to wash hands and dry with paper towel. Remove old dressing and dispose in biohazard waste. Remove gloves and wash hands with soap and water. [NAME] new gloves .Place non-occlusive dressing around catheter with foam pad side next to elder's skin. Apply transparent dressing. Label dressing with date dressing was changed, if PICC line is sutured or non-sutured and the initials of nurse who changed dressing and date of dressing change .Document procedure and assessment findings in the clinical record. Removal of PICC line: must be completed by an RN. Must have a physician order to remove PICC line . Remove dressing and assess site .If sutured in place, sutures must be removed prior to pressure on PICC line tubing. Once sutures removed, gently pull on PICC line to remove. Apply gentle pressure with clean sponge gauze until bleeding has stopped .Place gentle dressing as needed over PICC line site. Measurement of PICC line will be obtained by measuring the entire length of the PICC line removed and recorded in the clinical record prior to biohazard disposal of the PICC line and tubing. Comparison measurement with documented or reported measurement of the line at the time of insertion must be confirmed and if variance is present, the physician must be notified immediately.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 20042 Based on observation, interview, and record review, the facility failed to ensure a resident (R134) received oxygen per nasal canula for 1 of 1 resident (R134) reviewed for oxygen administration in the sample of 20. The findings include: On 1/28/25 at 10:05 AM, V10 (R134's family) was outside of R134's room yelling and demanding to know why R134 did not have any oxygen on. The surveyor went into R134's room, V10 followed, and V10 was visibly upset. V10 stated she wanted to know why R134 did not have his oxygen in place when they arrived at the facility. V10 stated V11 (R134's family) applied the nasal cannula to R134's face. V10 stated R134 is oxygen dependent. V11 was sitting on the end of R134's bed. V11 stated the nasal cannula was hanging over there and pointed to the flow meter on the wall at the head of his bed. V11 stated this is not the first time this has happened. R134 had a nasal cannula on his face and his flow meter was set at 3 liters of oxygen. R134 stated he did not know why his oxygen was over there. On 1/29/25 at 11:36 AM, V6 CNA (Certified Nursing Assistant) stated she was R134's aide yesterday and when she went into his room to change his bed and clean him up his oxygen was off and to the side of his face. V6 stated she put the oxygen back on and did not know anything about R134's nasal cannula not being on. V6 stated she did not know anything about R134's nasal cannula hanging on the flow meter in the room. On 1/29/25 at 2:05 PM, V2 D.O.N. (Director of Nursing) stated she would need to see why R134 did not have oxygen on. V2 stated if R134 has an order for oxygen then he should have the oxygen on unless there were orders for weaning the oxygen. V2 stated she couldn't imagine R134 having orders to wean oxygen if he has chronic respiratory failure. The Progress notes for R134 from Admission on 1/17/25 through 1/27/25 did not show any documentation of R134 removing his nasal cannula, refusing to wear the nasal cannula, or refusal of oxygen administration. The Physician Order Summary Report dated 1/30/25 showed an order dated 1/28/25 for oxygen at 3 liters per nasal cannula continuously. The Face Sheet dated 1/30/25 for R134 showed diagnoses including chronic respiratory failure with hypoxia, repeated falls, fracture of left shoulder, type 2 diabetes mellitus, Parkinson's disease, hypertension, paroxysmal atrial fibrillation, and dependence on supplemental oxygen. The Care Plan dated 1/17/25 for R134 showed, R134 requires oxygen therapy related to chronic respiratory failure with hypoxia. Oxygen as ordered by medical doctor; see orders. Administer oxygen per physician's orders. (continued on next page)

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	146192	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thrive of Lisle	2850 Ogden Avenue Lisle, IL 60532

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility's Oxygen Administration policy (no date) showed, place appropriate oxygen device on resident. Check mask, tank, humidifying jar, etc., to be sure they are in good working order and are securely fastened. Observe the resident upon setup and periodically thereafter to be sure oxygen is being tolerated.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 34491 Based on observation, interview and record review, the facility failed to ensure a pain patch was removed as ordered (R129) and failed to ensure nursing staff documented in the controlled medications reconciliation sheets as soon as medications were removed from the medication cart (R142 and R144). These failures apply to 1 resident (R129) in the sample of 20 reviewed for medication administration, and 2 residents (R142 and R144) outside of the sample. The findings include: 1. R129's Admission Record, printed by the facility on 1/30/25, showed she had diagnoses including a right femur fracture, a wedge compression fracture of first and third lumbar vertebra, and bilateral primary osteoarthritis of hip. R129's 1/22/25 facility assessment showed she was cognitively intact, required partial to moderate assistance from staff for bed mobility, upper body dressing, and transfers. The assessment showed R129 required substantial to maximal assistance from staff for toileting and lower body dressing. On 1/29/25 at 8:34 AM, V14 (Licensed Practical Nurse-LPN) prepared the AM medications for R129. The medications included a Lidocaine 5% patch. V14 went in to give R129 her oral medications, then informed R129 that she was going to put her pain patch on. R129 rolled over onto her right side and pulled her brief down. R129 said the previous patch was still on. V14 donned gloves and removed the old Lidocaine patch from R129's left lower back area. On 1/29/25 at 8:43 AM, V14 said the lidocaine patch should have already been removed because the order says 12 hours on and 12 hours off. V2 said it should be taken off as ordered. It could irritate the skin. On 1/30/25 at 11:26 AM, V2 (Director of Nursing-DON) said if a lidocaine patch is a 12-hour treatment order, then there is a length of time that it should be on the body. It should have been taken off when ordered. If the order says 9:00 AM on and 9:00 PM off, it should have been taken off at 9:00 PM. V2 said if left on longer than ordered it could cause skin irritation or could affect the efficacy of treatment. V2 said the resident could get too less, or too much medication. On 1/30/25 at 11:33 AM, R129 said the nurses were not removing the lidocaine patch after 12 hours. R129 was surprised to learn that the order for the Lidocaine patch was on for 12 hours, then off for 12 hours. R129 said the skin under the patch would get a little itchy, but no rash had developed. R129's Order Summary Report, printed by the facility on 1/29/25, showed an order for Lidocaine External Patch 5% (Lidocaine) Apply to left side back topically one time a day for pain. Apply 12 hours on and 12 hours off and remove per schedule. R129's January 2025 MAR (Medication Administration Record) showed the same order. The MAR showed the Lidocaine patch was applied on 1/28/25 around 9:00 AM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 1/29/25 at 9:36 AM, a review of the 2000 hall, (back-half of the 2000 hall) medication cart was conducted. At 9:48 AM, this surveyor informed V8 (Licensed Practical Nurse-LPN) that she wanted to review some of the medications in the locked, controlled medication compartment of the medication cart, and compare the count to the medication reconciliation binder. V8 said she wanted to sign something before we began. V8 signed off in the reconciliation binder for R144's Lyrica (a schedule V controlled medication for neuropathy pain) and R142's Norco (a schedule II-controlled pain medication). After signing off on R144 and R142's medications, the number of pills in the medication cards (31 capsules of R144's Lyrica and 14 pills of R142's Norco) matched what the medication reconciliation binder showed. On 1/29/25 at 9:56 AM, V8 said the medications should be signed off on when you give them, so you do not forget to sign them off, and so you sign off on the right person. R144's Admission Record, printed by the facility on 1/30/25, showed she had diagnoses including discitis (a rare, but serious condition that involves inflammation and infection of the spinal columns intervertebral discs that can cause severe back pain), and polyneuropathy (a peripheral nerve disorder that affects multiple nerves throughout the body simultaneously). R144's Order Summary Report, printed by the facility on 1/30/25, showed an order for Lyrica capsule 100 miligrams (mg). Give one capsule two times a day for neuropathy. R144's January 2025 Medication Administration Record (MAR) showed the Lyrica is scheduled for 9:00 AM and 9:00 PM. R142's Admission Record, printed by the facility on 1/30/25, showed she had diagnoses including a left femur fracture, and pain in left hip. R142's Order Summary Report, printed by the facility on 1/30/25, showed an order for Norco 5-325 mg (milligrams) give one tablet by mouth every 4 hours as needed for pain. R142's January 2025 Medication Administration Record (MAR) showed R1's Norco was administered at 9:08 AM on 1/29/25 (40 minutes before signing it out of the controlled medication reconciliation binder). On 1/30/25 at 11:20 AM, V2 (Director of Nursing-DON) said the nurse should sign out controlled medications in the reconciliation binder as soon as they pop the medication out of the card. V2 said it is important to do it so there is no Hey I dropped it, and no medication diversion. V2 said You are documenting that you pulled the medication out of the bingo (medication) card. The facility's November 2018 policy and procedure titled Narcotic Monitoring, showed 1. When a controlled substance arrives from the pharmacy, it should be immediately locked in the narcotic medication drawer, with the individual Narcotic Sign Out sheet being placed in a binder .3. When a narcotic medication is administered, it should be signed out in the individual Narcotic Sign Out record and pain flow sheet .4. Individual Narcotic Sign Out record should include date given, time given, dosage given, signature of nurse administering medications and number remaining.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39543 Based on observation, interview, and record review the facility failed to implement its infection control policy regarding contact isolation for a resident with a multi drug resistant organism (MDRO). This applies to 1 (R228) of 3 residents reviewed for infection control policies in the sample of 20. The findings include: R228's Admission Record (Face Sheet) showed he was admitted to the facility on [DATE]. The face sheet showed his primary diagnosis was Clostridium Difficile (C.Diff, an MDRO which can cause severe diarrhea.) R228's Active Orders (As of 1/30/25) showed an order for Contact Isolation: Strict one room isolation with all services provided in room alone, C.Diff.) The order showed it was started on 1/20/25. On 1/28/25 at 10:43 AM, R228's door showed a yellow Contact Isolation sign. This sign is standard and provided by the Centers for Disease Control. The sign did indicate hand hygiene was required; however, it did not show/state that hand washing was required. The interior of R228's door had no posting indicating hand washing was required. R228's door did not have a posting indicating staff assistance/notification was required prior to entry. On 1/29/25 at 11:58 AM, V4 Certified Nursing Assistant (CNA) stated she was R228's CNA for the day. V4 stated she is dependent upon the nurse to know which residents have C.Diff. V4 said she did not have any residents with C.Diff. V4 said residents with C.Diff require gowns and gloves. V4 said, after providing care for C.Diff residents, handwashing is required. V4 said there is no posting on doors for residents with C.Diff to notify family, visitors, dietary staff that handwashing is required. On 1/30/25 at 9:41 AM, V3 Infection Preventionist stated alcohol-based hand rub does not kill C.Diff spores. V3 said handwashing is required to prevent the spread of C.Diff to other residents and staff. On 1/30/25 at 11:39 AM, V3 stated R228 is in isolation for C.Diff. V3 stated R228 only had the standard yellow contact isolation sign on the door; however, she has now posted inside the door a sign indicating hand washing is required. V3 stated she was not aware the facility's policy required a blue contact isolation sign for C.Diff. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The facility's Infection Control Policy (Revision/Reviewed on May 2024) showed, .The resident's clinical record and door will display the appropriate isolation notification by nursing staff .Signage will refer viewers to the nurse to inquire about procedures to be followed. Nursing staff will instruct the resident and visitors about precautions to follow while visiting or attending to the resident in isolation. The policy continued, Staff will be notified during each shift report of the type of transmission-based precautions a resident is placed on and the reason .A resident with C.Difficile infection will be placed on special contact precautions. Special contact precautions require the use of gowns and gloves upon entry to room, soap and water for hand hygiene after contact with the resident or their care environment .Resident rooms for special contact precautions will be designated with a blue sign .

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34491 Based on interview and record review, the facility failed to offer an influenza and/or pneumonia vaccines for 4 of 5 residents (R2, R56, R228, and R230) reviewed for immunizations in the sample of 20. The findings include: On 1/30/25, five selected residents from the sample were reviewed for immunizations. The review showed: R2's Admission Record, printed by the facility on 1/30/25, showed she had diagnoses including, but not limited to, chronic kidney disease-stage 3, atherosclerotic heart disease, chronic diastolic (congestive) heart failure, urinary tract infection, metabolic encephalopathy, atrial fibrillation, and presence of a prosthetic heart valve. The record showed R2 was admitted to the facility on [DATE]. R2's electronic immunization tab showed the last pneumonia vaccine she received was on 2/7/2015. R56's Admission Record, printed by the facility on 1/30/25, showed he was admitted to the facility on [DATE]. The record showed he had diagnoses including, but not limited to, paroxysmal atrial fibrillation, chronic obstructive pulmonary disease, peripheral vascular disease, hypertension, malignant neoplasm of prostate, cardiomyopathy, and presence of a cardiac pacemaker. R56's immunization record, provided by the facility on 1/30/25, showed his last pneumonia vaccine (and only pneumonia vaccine listed) was the pneumococcal 20-valent on 8/17/23. R228's Admission Record, printed by the facility on 1/30/25, showed he was admitted to the facility on [DATE] with diagnoses including, but not limited to, chronic obstructive pulmonary disease, Clostridium difficile, chronic kidney disease-stage 3, atrial fibrillation, chronic diastolic (congestive) heart failure, and dependence on supplemental oxygen. R228's immunization record, provided by the facility on 1/30/25, showed his last pneumococcal vaccine was on 5/7/2015. R230's Admission Record, printed by the facility on 1/30/25, showed he was admitted to the facility on [DATE] with diagnoses including, but not limited to, Covid-19, acute respiratory failure with hypoxia, myocardial infarction, acute kidney failure, hypertension, atherosclerotic heart disease, and presence of aortocoronary bypass graft. R230's immunization record, provided by the facility on 1/30/25 showed no influenza immunizations. The record showed R230's last pneumococcal vaccine was the pneumococcal 23-valent on 1/14/2020. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On 1/30/25 at 9:58 AM, V3 (Infection Preventionist-IP/Registered Nurse-RN) said the facility has such a fast turnover rate due to it being an acute rehab facility. V3 said the facility has someone from a local pharmacy come in once a month and they do a vaccine clinic. V3 said any of the residents that are eligible and would like a vaccine are offered it, if they are in the facility when the person from the local pharmacy comes. V3 said the facility has talked to the pharmacy representative that does the vaccine immunizations and they are going to start coming in twice a month, starting next month (February 2025). V3 said the next vaccine clinic is scheduled for 2/14/25. V3 said if a resident is a candidate for the influenza, pneumonia, Covid-19, or RSV vaccine, and are going to be in the facility during that time, the facility will offer them the vaccine. V3 said she will wait until closer to 2/14/25 to ask them if they would like the vaccines and provide them information regarding the risks and benefits. V3 was asked to provide all documentation she had regarding asking the 5 residents that were reviewed for immunizations, showing the facility offered them any vaccines, and if declined, then to provide the declination forms. No documentation showing R2, R56, R228, or R230 were offered the vaccines, or declination forms were provided prior to exiting the facility. On 1/30/25 at 12:46 PM, V1 (Administrator) said the facility is working with the pharmacy to increase the vaccine clinics to twice a month, so they can catch and offer all the residents any vaccines they are eligible for. The facility's policy and procedure titled Pneumonia and Influenza Vaccine, with a revision date of October 2024, showed The Advisory Committee on Immunization Practices recommends vaccinating persons who are at high risk for serious complications from influenza and/or pneumonia, including those [AGE] years of age and older, who are residents of nursing homes . The policy showed Procedures: All current and newly admitted residents, all staff, and volunteers will be offered the influenza vaccine from October 1 of each year through March 31 of the following year. All admissions during the policy administration period will be offered the influenza vaccine developed for the current year after investigation/inquiry related to current immunization statis. All admissions throughout the year will be offered the Pneumovax injection as desired by the resident and approved by the primary care physician after investigation/inquiry related to current immunization status.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34491 Based on interview and record review, the facility failed to offer the Covid-19 vaccine for 2 of 5 residents (R56 and R228) reviewed for immunizations in the sample of 20. The findings include: On 1/30/25, a review of R56 and R228's electronic medical records showed: R56's Admission Record, printed by the facility on 1/30/25, showed he was admitted to the facility on [DATE]. The record showed he had diagnoses including, but not limited to, paroxysmal atrial fibrillation, chronic obstructive pulmonary disease, peripheral vascular disease, hypertension, malignant neoplasm of prostate, cardiomyopathy, and presence of a cardiac pacemaker. R56's immunization record, provided by the facility on 1/30/25, showed his last SARS Cov-2 vaccine was on 9/21/2023. R228's Admission Record, printed by the facility on 1/30/25, showed he was admitted to the facility on [DATE] with diagnoses including, but not limited to, chronic obstructive pulmonary disease, Clostridium difficile, chronic kidney disease-stage 3, atrial fibrillation, chronic diastolic (congestive) heart failure, and dependence on supplemental oxygen. R228's immunization record, provided by the facility on 1/30/25, showed his last SARS-COV-2 vaccine was on 12/11/2021. On 1/30/25 at 9:58 AM, V3 (Infection Preventionist-IP/Registered Nurse-RN) said the facility has such a fast turnover rate due to it being an acute rehab facility. V3 said the facility has someone from a local pharmacy come in once a month and they do a vaccine clinic. V3 said any of the residents that are eligible and would like a vaccine are offered it, if they are in the facility when the person from the local pharmacy comes. V3 said the facility has talked to the pharmacy representative that does the vaccine immunizations and they are going to start coming in twice a month, starting next month (February 2025). V3 said the next vaccine clinic is scheduled for 2/14/25. V3 said if a resident is a candidate for the Covid-19 vaccine and are going to be in the facility during that time, the facility will offer them the vaccine. V3 said she will wait until closer to 2/14/25 to ask them if they would like the vaccines and provide them information regarding the risks and benefits. V3 was asked to provide all documentation she had showing the facility offered them the vaccines, and if declined, then to provide the declination forms. No documentation showing R56 or R228 were offered the vaccines, or declination forms were provided prior to exiting the facility. On 1/30/25 at 12:46 PM, V1 (Administrator) said the facility is working with the pharmacy to increase the vaccine clinics to twice a month, so they can catch and offer all the residents any vaccines they are eligible for.