STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146194	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thrive of Fox Valley	4020 E New York Street Aurora, IL 60504

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide educational instructions for a resident (R5) discharging with a cardiac monitor.This applies to 1 of 4 residents (R5) reviewed for discharges.The findings include:R5's EMR (Electronic Medical Record) said he was admitted to the facility on [DATE] with multiple diagnoses, including a new onset of cardiomyopathy, which required the use of a cardiac vest monitoring device. R5's MDS (Minimum Data Set) dated 3/20/2026 said he was cognitively intact and able to follow instructions. The EMR said he was discharged home on 3/20/2026, still requiring the use of the monitor.On 4/01/2026 at 12:30 PM, V21 (Registered Nurse/RN) said she readmitted R5 on 3/06/2026 and routinely cared for R5 during his stay at the facility. V21 said R5 did not have cardiac monitoring orders during his stay, and she forgot to enter them when he was readmitted . V21 said the orders were needed to ensure the monitor was checked to be working properly every shift. V21 said R5's cardiac monitor required daily battery changes to ensure his cardiac data was being transmitted off-site to his cardiologist. V21 said R5 would routinely call when his vest started to alarm or needed to be adjusted. V21 said she was unsure if R5 knew how to care for the monitor, but the nursing staff changed and charged the battery for him daily.R5's Order Summary Report for his readmission on [DATE] did not show an order for his cardiac vest monitor care. The report said he was admitted to the facility's Cardiopulmonary Program due to his diagnoses of pulmonary embolism and respiratory failure.R5's comprehensive care plan, initiated on 1/31/2026, said he was to discharge home. The care plan had multiple interventions, including Establish a pre-discharge plan with the resident/family/caregivers and evaluate progress and revise plan as needed. The care plan did not include a focus problem for his new cardiac condition and management of the cardiac vest monitor.On 4/01/2026 at 11 AM, V20 (RN) said she discharged R5 on 3/20/2026. V20 said R5 was discharged with his cardiac vest monitor in place. V20 said R5 did not have active orders for the management of his monitor but assumed that the battery was changed by the overnight nurse. V20 confirmed R5's vest was working, and he took the monitor's charger and extra battery with him. V20 said she assumed R5 knew how to care for the monitor and did not provide him with specific instructions. V20 said she provided R5 with his discharge summary form and a list of his medications. V20 said cardiac monitoring instructions were important to ensure the guest knows how to monitor complications and prevent readmissions.R5's Transition Home discharge form dated 3/20/2026 said he was discharged with a cardiac vest monitor. The form did not show R5 received specific discharge nursing instructions regarding the management of his cardiac device, cardiac complications, cardiology follow-up, and who to contact in case of device complications.On 4/01/2026 at 10:20 AM, V3 (Assistant Director of Nursing/ADON) said she reviewed R5's EMR and was unable to identify which cardiologist was managing his cardiac device. V3 said R5's EMR also did not show orders for nursing management of the device. V3 said R5 was admitted to the facility's Cardiopulmonary Program, but she was unfamiliar with the program's services. V3 further said the facility was unaware that R5 was readmitted to the ER (Emergency Room) after he was discharged on 3/23/2026 due to complications related to his cardiac device.R5's ER hospital note dated 3/23/2026 said he (continued on next page)

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	presented with bilateral lower extremity edema, which started after he was discharged from the facility. The note said R5 was previously given a LifeVest (cardiac monitor) due to his severe cardiomyopathy. R5 presented without the vest in place and reported it was not working due to battery complications. After multiple cardiac tests and a cardiology consult, R5 was discharged home with strict return precautions. R5 was educated on contacting the device's company for further assistance and how to monitor for cardiac complications.The facility's document titled Specialized Cardiopulmonary Program, undated, said the mission statement was to focus on patients with cardiac and respiratory disease and provide them with evidence-based treatment. Also, provide them with education and resources that would allow the patient to manage their disease process and achieve optimal outcomes. The programs discharging planning including determining their equipment needs and education.The facility's document titled LifeVest Questions and Answers, dated 2020, said the LifeVest was a wearable cardioverter defibrillator that was worn by patients at risk for sudden cardiac death (SCD). The device was designed to detect certain rapid life-threatening heart rhythms and automatically deliver a treatment shock to save a patient's life. It allows patients to return to most common activities for daily living with peace of mind that they have protection from SCD.The facility's policy titled Wearable Cardioverter-Defibrillator, dated 03/2023, said documentation was required for residents requiring the use of the device, including a prescription form from the prescribing physician. The policy included specific caring instructions for the device, including how frequently to change the battery, how to wash the vest, and how to respond to alerts.The facility's policy titled Discharges, dated 04/2023, said the facility would establish a discharge plan. Teaching would be done with the resident/family on any special tasks and would be documented in the nursing note/discharge note.

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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** Based on observation, interview, and record review, the facility failed to assess and treat a resident's (R2) skin conditions as ordered.This applies to 1 of 3 residents (R2) reviewed for skin care.The findings include:R2's care plan said she had actual and was at risk for further skin impairment due to her left lower leg cellulitis and chronic lymphedema. The care plan's interventions included for the nursing staff to evaluate and treat her skin as ordered. R2's MDS (Minimum Data Set) dated 3/25/2026 said she was cognitively intact. R2's EMR (Electronic Medical Record) showed she had an active order for Nystatin powder (antifungal) to be applied to under her breast twice a day and wound consults as needed.On 3/27/2026 at 11:40 AM, R2 said she was upset and frustrated because on the evening of 3/26/2026, she requested V5 (Registered Nurse/RN) to assess her new open wound to her left anterior thigh but V5 did not assess or treat her wound. R2 said she was concerned regarding skin impairment because she was currently being treated for cellulitis (skin infection) on her left leg. R2 said her wound remained untreated and uncovered. R2 had an open linear wound to her left anterior mid-thigh area. R2 continued to say she had also requested her antifungal powder be applied as ordered to treat her rash under her left breast, but it was routinely not administered. R2 had a fungal rash underneath her left breast.R2's Medication Concern form dated 3/24/2026, showed she filed her concern regarding not receiving her Nystatin treatment as ordered.R2's ETAR (Electronic Treatment Administration Record) for March 2026 showed multiple omissions for the administration of Nystatin powder as ordered on 3/19/2026, 3/20/2026, 3/21/2026, 3/22/2026, 3/23/2026, and 3/24/2026.On 3/31/2026 at 10:40 AM, V5 (RN) said on 3/26/2026 she was assigned to R2. V5 said she was unsure if R2 reported her new skin alteration.On 3/27/2026 at 12:20 PM, V4 (Wound Care Nurse/WCN) said she was not aware of R2's new open wound to her left thigh. V4 assessed R2's skin and said her new open wound measured 3 x 0.4 x 0.1 cm (centimeters) and had serosanguinous drainage. V4 also said R2's fungal rash on her left breast still required ongoing treatment as ordered. V4 said she expected nurses to assess new skin alterations and notify the physician to obtain and initiate treatments. V4 also said nurses were expected to review the residents' ETARs and administer treatments as ordered to ensure proper skin management.R2's Wound Summary assessment dated [DATE] said her new facility-acquired trauma wound was classified as an abrasion to her left medial thigh distal. The wound measured 3 x 0.4 x 0.1 cm with 100 % bright pink or red tissue with serosanguinous drainage.The facility's policy titled Wound Policy and Procedure, dated 01/2026, said the facility was committed to providing a comprehensive wound management program to promote the residents' highest level of function and well-being. Any resident with a wound would receive treatment and services consistent with the resident's goals of treatment. Typically, the goal is one of promoting healing and preventing infections. The policy said accountability was part of the facility's Wound Management Program, which identified staff participation to prevent and treat wounds accordingly.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to safely transport a resident (R1) in a wheelchair, resulting in him falling and sustaining multiple lacerations.This applies to 1 of 3 residents (R1) reviewed for accidents.The findings include:R1's EMR (Electronic Medical Record) showed he was admitted to the facility on [DATE] with multiple diagnoses, including chronic renal failure, dependent on hemodialysis, unsteadiness on his feet, need for assistance with personal care, reduced mobility, and glaucoma. R1's MDS (Minimum Data Set) dated 1/22/2026 said he was cognitively intact and was dependent with his transfers and lower body care needs. R1's Fall Risk Evaluation dated 1/15/2026 said he was at a high risk for falls. The EMR said he was transferred to the hospital on 3/11/2026 after he sustained a witnessed fall and did not return to the facility.On 3/31/2026 at 1 PM, R1 was interviewed over the phone. R1 said on 3/11/2026, V10 (Certified Nurse Assistant/CNA) was wheeling him in a wheelchair down the hallway after his dialysis treatment. When V10 all of a sudden stopped, it caused him to fly off his wheelchair because there was no footrest. R1 said he was unsure why V10 stopped suddenly when wheeling him. R1 said he sustained abrasions to his left knee and elbows, and his left knee still required treatment. R1 said he went to the hospital and was originally evaluated for possible acute left knee fracture and head injury, but the exams were negative for acute injuries. R1 continued to say that he was too upset after the incident and decided not to return to the facility. R1 said he was discharged to another facility for further rehab services.R1's fall incident dated 3/11/2026, said he had a witnessed fall in the hallway at 11:10 AM. R1 was being wheeled by V10 when he fell forward. R1 sustained lacerations to both his elbows and knees, and an abrasion to the top of his scalp.On 3/31/2026, multiple attempts were made to interview V10 (CNA) but remained unavailable.V10's (CNA) witness statement document dated 3/11/2026, said I was pushing patient from dialysis in the wheelchair, and he fell out the wheelchair onto the floor.On 3/31/2026 at 11 AM, V12 (Registered Nurse/RN) said she witnessed V10 wheeling R1 on 3/11/2026. V12 said V10 (CNA) suddenly stopped, and then R1 fell forward on his left side. V12 said she immediately assessed R1, and there was no footrest present. V12 said the footrest should have been used for proper positioning and to ensure safe transport.On 3/27/2026 at 2:40 PM, V14 (Physical Therapist Assistant) said R1 required the use of a wheelchair due to generalized fatigue. V14 said R1 also required nursing staff assistance and the use of footrests for his wheelchair mobility. V14 said R1 never displayed poor safety noncompliance with the use of his wheelchair, and his footrest should have been used to ensure his safety.On 3/27/2026 at 1 PM, V1 (Assistant Administrator) said V10 (CNA) was terminated after R1's fall incident because the facility was unable to confirm if the footrests were used during their investigation. V1 said the facility determined R1 abruptly fell forward because V10 failed to provide proper trunk support, causing his feet to go down. V1 said the facility expected the nursing staff to implement proper safety measures when transporting a resident in a wheelchair to ensure their safety.V10's (CNA) Performance Form dated 3/16/2026, said she transported [R1] that was weak after HD towards his room without taking appropriate support measures. Which led to the guest having subsequent fall with injuries. The form said V10 failed to follow the facility's safety procedures which jeopardized the safety of R1.R1's fall care plan was updated on 3/12/2026 and showed multiple interventions, including staff to ensure R1 was provided proper trunk support after dialysis when being transported, and anticipate his needs to prevent further incidents.R1's final fall investigation dated 3/16/2026, said R1 was admitted to the hospital and that the facility would reassess his wheelchair upon his return.The facility's policy titled Fall Prevention dated 01/2026, said the facility would provide services and care that ensures that the resident's environment remained as free from accidents hazards as is possible and each resident receives adequate supervision and assistive devices to prevent accidents. The policy continued to say that the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interdisciplinary team would develop a plan for services to improve or maintain the resident's standing and sitting balance and other interventions to reduce the resident's risk for falls. The residents' plan would include specific, individualized information about the residents to reduce their risk for falls. And that interviews would be done with the residents to determine any factors that may predispose them for a fall with the goal to help prevent falls in their environment.The facility's policy titled Transfers Within the Facility dated 02/2025, said the facility would determine residents transfer ability according to resident transfer evaluation or therapy recommendations, and would according implement the recommendations. The policy also said footrests would be used for transport, and if not, the transport would be done slowly.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interview and record review, the facility failed to administer a resident's (R2) as needed analgesic when requested.This applies to 1 of 3 residents (R2) reviewed for pain management.The findings include:R2's care plan said she had the potential for pain due to her chronic pain syndrome. The care plan had multiple interventions, including her need to receive her opioid medication as ordered. Also, for the staff to anticipate her need for pain relief and respond immediately to any complaint of pain. R2's MDS (Minimum Data Set) dated 3/25/2026 said she was cognitively intact. R2's EMR (Electronic Medical Record) showed she had an active order for Norco (analgesic) 10-325 mg (milligrams) one tablet every six hours as needed for pain.On 3/27/2026 at 11:40 AM, R2 said she was upset and frustrated because on the evening of 3/26/2026, she called to request Norco and did not receive it when requested. R2 said V7 (CNA/Certified Nurse Assistant) responded to her call light multiple times after she continued to call repeatedly for her medication. R2 said V7 informed her she had notified V5 (Registered Nurse/RN) of her request. R2 said she had chronic pain but was also experiencing acute pain in her left leg due to her cellulitis (skin infection). R2 said V5 finally administered her Norco at approximately 9:30 PM (approximately 3.5 hours later). R2 said V5 was unable to explain why there was a delay in her receiving her as-needed pain medication as requested.On 3/31/2026 at 10 AM, V7 (CNA) said on 3/26/2026, R2 called for her pain medication at around 6 PM, and she notified V5 (RN). V7 said, then R2 continued to call multiple times afterwards regarding her pain medication, and she continued to notify V5 of her request.R2's call light log document showed that on 3/26/2026, she called at 6:06 PM and continued to call an additional five times at 6:15 PM, 7:28 PM, 8:07 PM, 8:41 PM, and 9:13 PM.On 3/31/2026 at 10:40 AM, V5 (RN) said on 3/26/2026 at around 9 PM, another nurse on duty was going to administer R2's pain medication but did not have access to the medication. V5 said she then responded to R2's request, and R2 was upset when she administered her pain medication. V5 said she was unsure when she was originally notified of R2's request. R2's EMAR (Electronic Medication Administration Record) showed V5 (RN) administered her as needed (PRN) Norco 10-325 mg at 9:26 PM on 3/26/2026 and she was able to receive it after 6 PM.On 3/27/2026 at 1:20 PM, V2 (Director of Nursing/DON) said nurses were expected to administer pain medications as ordered upon request to ensure residents with pain were medicated appropriately. The facility's policy titled Pain Management, dated 1/01/2026, said the facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.