(X6) DATE

Illinois Department of Public Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		IL6016968	B. WING		02/2	7/2024	
		120010908			03/2	112024	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
THRIVE OF LISLE 2850 OGDEN AVENUE LISLE, IL 60532							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
S 000	Initial Comments		S 000				
	Annual Licensure S	urvey					
S9999	Final Observations		S9999				
	Statement of Licens	sure Violations:					
	1 of 1						
	300.615 e)						
	Screening and Req History Record Info e) In addition to the Section 2-201.5(a) of facility shall, within 2 resident, request a check pursuant to the Information Act for seeking admission background checks pursuant to the Hos Background checks resident's name, da	e screening required by of the Act and this Section, a 24 hours after admission of a criminal history background he Uniform Conviction all persons 18 or older to the facility, unless a was initiated by a hospital spital Licensing Act. Is shall be based on the stee of birth, and other ed by the Department of State					
	These requirements by:	s were not met as evidenced					
	review, the facility fachecks for 6 resider admission. This app	on, interview, and record ailed to complete background nts within 24 hours of blies to 6 of 10 residents , R133, R132, R131) reviewed cks.					
	The findings include	e:					

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 04/05/24

TITLE

STATE FORM 6899 G2GK11 If continuation sheet 1 of 3 Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		IL6016968	B. WING		03/2	7/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
THRIVE	THRIVE OF LISLE 2850 OGDEN AVENUE LISLE, IL 60532						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
S9999	Continued From page 1		S9999				
	admitted on 3/23/24 3/23/24, R178 was was admitted on 3/ 3/22/24, and R131 R335's Criminal His	ed 3/25/24, shows R335 was 4, R226 was admitted on admitted on 3/22/24, R133 22/24, R132 was admitted on was admitted on 3/22/24.					
	Process form was run on 3/25/24; two days after R335 was admitted.						
	R226's Criminal History Information Response Process form was run on 3/25/24; two days after R226 was admitted. R178's Criminal History Information Response Process form was run on 3/25/24; three days after R178 was admitted.						
		story Information Response run on 3/25/24; three days nitted.					
		story Information Response run on 3/25/24; three days nitted.					
		story Information Response run on 3/25/24; three days nitted.					
	Coordinator) said R R133's, R132's, and were run on the mo- returned to work fro process for residen weekend is for V24 on Monday morning	AM, V24 (Admissions R335's, R226's, R178's, d R131's background checks orning of 3/25/24 when V24 om the weekend. The current ts who were admitted over the to run the background checks g. No background checks have med if a resident is admitted					

Illinois Department of Public Health

STATE FORM 6899 G2GK11 If continuation sheet 2 of 3

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMP	(X3) DATE SURVEY COMPLETED	
		IL6016968	B. WING		03/	27/2024	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
THRIVE OF LISLE 2850 OGDEN AVENUE LISLE, IL 60532							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
S9999	Continued From page 2		S9999				
	on a Saturday or Su	ınday.					
	(C)						

Illinois Department of Public Health

STATE FORM 6899 G2GK11 If continuation sheet 3 of 3