STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010052	A. BUILDING: _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THRIVE OF LAKE COUNTY	850 E US HIGHWAY 45 MUNDELEIN, IL 60060

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S 000	Initial Comments FRI of 3/6/2025/IL188826	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6 Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999		

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S9999	Continued From page 1 d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These Requirements were NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure a resident was supervised for 1 of 4 residents (R1) reviewed for safety and supervision in the sample of 4. This failure resulted in R1 falling and sustaining fractures to her pelvis. The findings include: On 3/25/25 at 12:01 PM, V3, Licensed Practical Nurse (LPN), said she was R1's nurse on 3/6/25. V3 said V3 said R1 kept trying to get up out of her wheelchair and she kept reminding R1 to sit back down. V3 said she stepped away from the dining room where R1 was sitting with other residents and the next thing she knew; a hospice nurse was telling her that R1 had fallen. V3 said R1 needed "one on one monitoring; you cannot really take [your] eyes off her." V3 said the Certified Nursing Assistants (CNAs) were monitoring the dining room, but they were busy, and they were not present at the time.	S9999		

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S9999	Continued From page 2 On 3/25/25 at 1:35 PM, V4, CNA, said she was assigned to care for R1 when R1 fell on 3/6/25. V4 said she was passing meal trays in the dining room with V3 and V7, CNA, where R1 was eating. V4 said she told V3 she was going to leave the dining room to feed residents in their rooms. V4 said she returned to the dining room after feeding a resident in their room and R1 was on the floor. V4 said she did not see R1 fall. V4 said she heard V3 say she was just there (in the dining room) five minutes ago. V4 said she had been told to monitor R1 more closely in report. V4 said R1 would try to get up out of her wheelchair and they would have to remind her to sit back in the chair. On 3/25/25 at 3:00 PM, V7, CNA, said she was assigned to R1's unit when R1 fell in the dining room (on 3/6/25). V7 said V4 was R1's CNA. V7 said she was with some residents; she heard commotion and then saw everyone going toward R1. V7 said she did not see R1 fall. V7 said staff should always monitor residents when they are in the dining room. V7 then said she does not remember what happened, she cannot recall everything since it's been such a long time. V7 said if she gave a statement at the time, it must be correct. On 3/25/25 at 2:26 PM, V2, Director of Nursing (DON), said R1 was a "frequent faller." V2 said she investigated the fall. R1 was found on the floor in the dining room on 3/6/25 around 1:20 PM. V2 said V3 said she was passing medications and did not see anything. V2 said it was an unwitnessed fall and R1 was not able to describe what happened. V2 said residents are supposed to be monitored by staff when they are in the dining room.	S9999		

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S9999	Continued From page 3	S9999		

V3 documented the following excerpt in R1's Progress Notes on 3/6/25 at 3:07 PM, "This resident since the beginning of the shift has been trying to get up from her wheelchair and every attempt to redirect her failed."

On 3/25/25 at 1:55 PM, V6, R1's Daughter, said R1 fell on 3/6/25. V6 said she was told R1 kept trying to get out of her wheelchair. V6 said R1 had x-rays on 3/7/25 and again on 3/10/25 which did not show any fractures. V6 said R1 would continue to scream with pain upon movement, so they pushed for a CT scan which was scheduled on 3/21/25. V6 said the CT scan showed two fractures. V6 said she feels there should be more safety precautions for the residents; more frequent checking or alarms or something.

On 3/25/25 at 3:09 PM, V8, R1's Orthopedic Surgeon, said R1 sustained pubic rami fractures which have shifted or moved according to her CT results. V8 said the fractures are definitely acute and were sustained within the last six weeks. V8 said these types of fractures occur after some type of trauma.

R1's CT of her pelvis dated 3/21/25 shows she has fractures of her right superior and inferior pubic rami. R1's Fall Risk Evaluations done on 12/27/24, 2/28/25, 3/2/25 and 3/6/25 all show she is a high risk to fall. R1's Care Plan initiated on 12/27/24 shows R1 is a high risk for falls related to impaired cognition and poor safety awareness. The same care plan shows R1's diagnoses include, but are not limited to vascular dementia, a history of falling, osteoporosis, and vitamin D deficiency.

The facility's Witness Statement dated 3/6/25 provided by V3 shows she was informed that R1

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S9999	Continued From page 4 had fallen by a hospice nurse who happened to be seeing another patient on the unit. The facility's Witness Statement provided by V7 dated 3/10/25 regarding R1's fall on 3/6/25 shows V7 said that she was not assigned to R1's unit. The facility's Initial and Final State Report dated 3/21/25 shows R1 is alert and oriented to self and has moderate cognitive impairment. The facility's Fall Prevention Policy (last revised 11/2024) shows, "Each resident residing at this facility ...receives adequate supervision ...to prevent accidents." (A)	S9999		