PRINTED: 05/01/2025 FORM APPROVED

(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING			
		IL6010052	B. WING	·····	03/13/2025	
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STATE	E, ZIP CODE		
THRIVE O	F LAKE COUNTY		HIGHWAY 45			
			EIN, IL 60060			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
S 000	Initial Comments		S 000			
	Annual Licensure Cer	rtification Survey				
S9999	Final Observations		S9999			
	Statement of Licensu	re Violations				
	300.610a)					
	300.1210b) 300.1210d)1					
	300.1210d)1 300.1210d)2					
	Section 300.610 Res	sident 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.					
	Nursing and Persona	eneral Requirements for I Care				
llin els D	and services to attain practicable physical, i well-being of the residence each resident's comp plan. Adequate and p care and personal car	rovide the necessary care or maintain the highest mental, and psychological dent, in accordance with rehensive resident care properly supervised nursing re shall be provided to each otal nursing and personal				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 03/21/25

TITLE

· '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE Co			E SURVEY PLETED		
			D. MING					
		IL6010052	B. WING		03	/13/2025		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE				
THRIVE O	THRIVE OF LAKE COUNTY 850 E US HIGHWAY 45							
11111111111	LAKE GOOKIT	MUNDEL	EIN, IL 60060					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE		
S9999	Continued From page	÷ 1	S9999					
	care needs of the res	ident.						
	Medications, inclu hypodermic, intravend be properly administer	ous and intramuscular, shall						
	All treatments and administered as order	•						
	These Requirements evidenced by:	were NOT MET as						
	failed to ensure a resi provided for 1 of 2 resi pain management in failures resulted in R1	nd record review, the facility ident's pain medications was sidents (R133) reviewed for the sample of 32. These 133 experiencing unrelieved ble to fully obtain restful						
	The findings include:							
	nights on the 8th thro receive her muscle re requested and indicat most" because she us relaxer with "norco" in R133 was told by stat ordered, and they wo She said that no one regarding the status of said the muscle relax (03/10/2025) and that	ted she "needed that the sually takes the muscle in the morning and at night. If that the medication was uld follow-up with pharmacy. If the medication. R133 then er came last night						

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, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	1 ' '	E SURVEY PLETED
		IL6010052	B. WING		03	3/13/2025
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, STATI	E, ZIP CODE		
THRIVE (OF LAKE COUNTY		HIGHWAY 45 EIN, IL 60060			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
\$9999	added that V4 (Licens that he had reordered was 5 pills left. Review of R133's me record for January 20 administered tizanidir 8th, 10th-14th, 16th-1 and the 30th. Review of R133's me record for February 2 administered tizanidir 7th, 9th, 11th, 13th-16 23rd-26th, and the 28 Review of R133's me record for March 2029 administered tizanidir 1st-2nd, 5th-9th, and Review of R133's pai months showed that of said she did not recei (tizanidine), a pain level on 03/08/2025 at 08:50 08:58 AM. Pain levels 03/10/2025 at 09:39 Apain level of "5" was of at 08:04 PM. Pain level on 03/11/2025 at 01:52 resident that medicatis showed she was adm 03/08/2025 and 03/08 upset then said, "that indicated that she did	dication administration 25 showed R133 was the 2mg tablet on the 1st-5th, 9th, 21st-24th, 26th-28th, dication administration 025 showed R133 was the 2mg tablet on the 1st-3rd, 6th, 18th-19th, 21st, 6th. dication administration 5 showed R133 was the 2mg tablet on the 1st-3rd, 6th, 18th-19th, 21st, 6th. dication administration 5 showed R133 was the 2mg tablet on the 1th-12th. In assessments for last 3 during the 3 days resident tive her muscle relaxer tivel of "5" was documented 67 AM and on 03/09/2025 at the of "8" were documented on AM and 09:42 AM, and a documented on 03/10/2025 the of "7" was documented	S9999			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S	
			A. BUILDING: _			
		IL6010052	B. WING		03/1	3/2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THRIVE O	F LAKE COUNTY		HIGHWAY 45 EIN, IL 60060			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
S9999	Continued From page	e 3	S9999			
	resident last admitted with a past medical h hypertension, bilatera other specified postp obesity, and muscle v Review of R133's car	al osteoarthritis of knee, rocedural states, morbid				
	anticipate the resider	t included but not limited to it's need for pain relief and to any complaint of pain.				
	impairment with an a Section J for health or requires pain manage scheduled and as ne Review of R133's act showed orders for pathydrocodone-acetam milligram (mg) tablet	ted in Section C for at R133 has no cognitive assessment score of 15/15. Conditions documented R133 at the semant and receives a ded pain medications. The semant are every shift, inophen (norco) 5-325 at the severy 8 hours as needed for a local 2mg tablet every 8 hours				
	visibly distraught said muscle relaxer medic "norco" for those 3 da was not fully controlle muscle spasms to the made it hard for her t R133 said she had as several times but was "didn't have any left a 01:56 PM, R57 (R133	52 PM, R133 who appeared I when she didn't take her sation (tizanidine) with ays (3/8-3/10/2025), her pain ed, and she was having e front of her legs which o sleep during those 3 days. sked for the tizanidine is told by the nurses that she and could only get norco". At 3's roommate) said a few as awoken by R133 who				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S	
			A. BOILDING.			
		IL6010052	B. WING		03/1	13/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THRIVE O	F LAKE COUNTY		HIGHWAY 45 EIN, IL 60060			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
S9999	said, "I felt so bad for she was hurting bad" On 03/13/2025, revie Mental Status (BIMS) indicated R57 has no cognitive response w On 03/12/2025 at 02: Practical Nurse) said tizanidine medication the morning and at nitizanidine medication 03/08/2025 and 15 ca 03/10/2025. Reviewe for tizanidine with V5 date of 03/10/2025. On 03/13/2025 at 11: Practical Nurse) said tizanidine medication had 3 or 4 capsules lewhen he reordered. On 03/13/2025 at 01: Nursing) said her expranage a resident's pain medication as or added that staff shou when there's a week' medication is unavail facility's automated m system. On 03/13/2025, revie medication dispension	dly in her sleep. R57 then her (R133) because I knew work of R57's Brief Interview for Evaluation dated 02/4/2025 cognitive impairment/ intact ith assessment score of 15. 05 PM, V5 (Licensed R133 usually requests her (muscle relaxant) daily in inght. V5 then said R133's was reordered last on apsules were received on d R133's medication card that showed a dispensed that he reordered R133's on 03/04/2025 and R133 eft on her medication card 00 PM, V2 (Director of pectation of staff is to pain by administering their redered and as needed. V2 ld reorder a medication is supply left and if a able, they should utilize the	S9999			
		istrator) also provided				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		IL6010052	B. WING		03/13/2025			
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE				
THRIVE O	THRIVE OF LAKE COUNTY 850 E US HIGHWAY 45							
			EIN, IL 60060					
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S9999	Continued From page	5	S9999					
	03/13/2025 for medical	ation administration.						
	from V1 (Administrator for V23 (Registered N documented administ R133 on 03/08/2025 adays that R133 was to had previously indicat medication. V23's corprovided during surve exiting the facility. On 03/13/2025, facilit report for R133's tizar documented 3 capsul	rations of tizanidine to and 03/09/2025 during the 3 old she had none left and ted not receiving the ntact information was not by or upon survey team y provided order detail nidine medication that es were dispensed on ication was not dispensed 5 with 15 capsules						
	02/2018 reads in part administered safely a residents to and help and prevent symptom	nd appropriately to aid in overcome illness, relieve is and help in diagnosisif ed but not available, check ced and then call the						
	reads in part: to ensur managed effectively. to respect and support optimal pain assessmant facility recognizes that decreased sensations Chronic pain may p depression, immobility	s or perceptions of pain roduce anorexia, lethargy, y, social isolationEach is a right to the assessment						

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NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
THRIVE C	F LAKE COUNTY	850 E US H MUNDEL FI	IGHWAY 45 N, IL 60060				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
S9999	management can ren psychological and ph unrelieved pain. Optin resident experiencing	nove the adverse	\$9999				

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