STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145986	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Forest Place	1100 Pembridge Drive Lake Forest, IL 60045

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 34490 Based on observation, interview and record review the facility failed to ensure a safe resident transfer and failed to ensure incontinence care was provided in a safe manner to prevent a fall. This failure resulted in R1 falling from bed during incontinence care and sustaining a femur fracture. This applies to 2 of 3 residents (R1 and R2) reviewed for safety in the sample of 3. The findings include: 1. R1's Minimum Data Set assessment dated [DATE] shows that her cognition is impaired, her vision is highly impaired, she is always incontinent of urine and stool, weighs 180 pounds and is dependent (Helper does all of the effort. Resident does none of the effort to complete the activity) for rolling left and right. On 2/26/25 at 11:24 AM, R1 was laying in bed. V5, Certified Nursing Assistant (CNA) and V4, Registered Nurse (RN) provided incontinence care to R1. R1 was confused and did not help with turning during the care. R1 was totally dependent on the staff during the care. R1 had a wound vac attached to her left upper leg. R1's Nursing Notes dated 2/15/25 shows, Around 1900 (7:00 PM) I was told by the nurse supervisor that the resident has fallen to the floor. Upon assessment resident was sitting on the floor by the window Per CNA she was changing the patient when she couldn't bare the weight when resident turned to one side and just lowered the bed On 2/27/25 at 12:24 PM, V7 (CNA) said that she was cleaning R1 up by herself because she had had a large bowel movement. V7 said that she turned R1 to the left side and her right leg was over her left leg and she began to fall off the bed. V7 said that R1 got too heavy to hold so she lowered her to the floor. V7 said that her legs hit the floor first but she is not sure what one. V7 said that she tried to get R1 back onto the bed when she started falling but she could not because she was too heavy. V7 stated, It was busy so I didn't have anyone to help me at the time. I usually do with two people. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 2/26/25 at 2:35 PM, V12 (RN Supervisor) said that she entered R1's room on 2/15/25 and saw R1 on the left side of her bed on the floor. V12 said that R1's buttock was sitting on top of V7's (CNA) feet and R1's back was on V7's legs. V12 said that V7 was the only staff member in the room when she came into the room. V12 said that she believes that R1 requires two staff members for incontinence care. On 2/26/25 at 2:11 PM, V13 (RN) said that she entered R1's room on 2/15/25 after she had heard that she had fallen. V13 said that when she entered, R1 was sitting on the ground on the left side of her bed and her back was leaning up against a recliner. V13 said that she asked V7 what had happened and she said that she was cleaning her and when she turned her to the side, her weight was put on one side and she couldn't hold her so she helped her down to the floor. V13 said that R1 is a little heavy and can not see very well so she is usually a two person assist for incontinence care. V13 said that she asked V7 if anyone was helping her and she said, no. R1's Nursing Notes dated 2/17/25 shows, At around 0300 (3:00 AM) while CNA assigned was giving care she noted that resident left knee is swollen ,night supervisor made aware and saw resident, upon assessment of this writer, noted resident left knee swollen, no bruising/redness but painful to touch,also noted that left leg appears shorter than RT (right) leg, and resident with facial grimacing and yelling ouch, ouch when area is touch. On 2/26/25 at 2:20 PM, V14 (RN) said that she was called to R1's room by the CNA. V14 said that when she did an assessment on R1, she noticed her left knee was swollen and her left leg appeared shorter than her right leg. V14 said that it was painful when she touched it. V14 said that she called the hospice nurse and notified her and the nurse said to give her ordered morphine and she will notify R1's routine hospice nurse. V14 said that she notified the oncoming nurse that she was awaiting a call back from hospice for additional guidance on what needs to be done. R1's Nursing Notes dated 2/18/25 shows, Late entry for 2/17/25. While siting in her [high back wheel chair] in the dining, resident stated I am not feeling well. Ask resident if in pain and where is the pain. No answer. Asked her again is your head hurting, again stated no this time. After breakfast resident was assisted by 2 CNAs back to bed and fell asleep right away. 2 RNs in the room to do an assessment. Found resident in the bed dorsal position with L (left) leg in the frog position. RN touched her dorsal aspect of L foot to feel pulse and she moaned, while resident is holding the L side of her pad. With 2 assist able to move her pant down below her knees and noted L thigh mid section with a hard bump, RN marked with a pen. Area is swollen and noted knee also edematous and bigger in size than the R (right) knee. Notified [Nurse Practitioner], in turn gave orders for xrays to be done. R1's X-Ray Report dated 2/17/25 shows, Impression: Left Hip: Metallic prosthesis in the left hip with mild protrusio acetabuli and oblique and slightly spiral fracture of the midshaft of the left femur. R1's Nursing Notes dated 2/17/25 at 5:28 PM shows, Call received at 17:28 (5:28 PM) from xray service to inform this writer that patient has a left femur fracture patient to be sent out to [Local hospital] for further evaluations. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R1's Hospital History and Physical dated 2/18/25 shows, Her hospice nurse is at bedside. Hx (history) obtained from this hospice RN and also pt's daughter on the phone. Pt. reportedly is bed-bound, AAO (alert and oriented) x 0-1/4 at baseline and fell off her bed when she was being cleaned about 2 days pta (prior to arrival). Had persistent pain after this and an XR (X-Ray) was eventually done which showed a L (left) hip fracture so she was brought in. R1's Hospital X-Ray dated 2/17/25 shows, There is a complete fracture through the mid femoral shaft with marked displacement and angulation. R1's Orthopedic Surgeon Note dated 2/18/25 shows, The patient is a 90 y.o (year old) female who has left femur fracture; ready for surgery today. Plan on left open reduction internal fixation femur On 2/26/24 at 4:11 PM, V15 (Orthopedic Surgeon) said that R1's fracture was due to a fall. V15 said that the fracture was also slightly spiralized which means there was some type of twisting motion involved as well. V15 said that R1's fracture was not pathological in nature. On 2/26/25 at 1:12 PM, V9 (CNA) said that she always has someone help her with incontinence care for R1 because she is not able to help with rolling. On 2/26/25 at 1:30 PM, V10 (CNA) said when providing incontinence care to R1, she usually uses two people because R1 can not help do anything. On 2/26/25 at 2:40 PM, V2 (Director of Nursing) said that R1 is confused and is totally dependant on staff for cares. V2 said that R1 uses a mechanical lift for transfers which requires two people so she typically has two staff members in the room to provide incontinence after they transfer her back to bed. V2 said that after the fall, they updated the assignment sheet to note that she needs two person assist for bed mobility and transfers. V2 said that before the incident, her care plan said 1-2 staff member for bed mobility. R1's Incident Note dated 2/15/25 shows that she had a witnessed fall. The note shows, CNA statement: When I was changing the resident as I turned her on her left side, she put all her weight on one side, and I was trying to hold her, but I couldn't hold her anymore, so I lowered the bed before guiding her to the floor . R1's Kardex Report dated 2/14/25 shows, Bed mobility:Lock wheels, give verbal cues and assist as needed. Needs to total assist of 1-2 staff with bed mobility. 2. R2's Transfer Guide assessment dated [DATE] shows that she requires two person assist with transfers. R2's Nursing Notes dated 1/31/25 shows, Patient arrived to skilled floor via wheelchair .Patient is alert and oriented x 1, to person only. Patient is a high fall risk and was placed in common area at admission .Writer received quick report from 1st floor nurse on new admission . 2 person assist, high fall risk . R2's Nursing Notes dated 2/3/25 shows, This RN (Registered Nurse) was called to shower room in A hallway by CNA (Certified Nursing Assistant) to assist with patient that was lowered to the floor by CNA during a wheelchair to toilet transfer. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 2/26/25 at 1:19 PM, V11 (CNA) said that she was toileting R2 on 2/3/25 when she was lowered to the floor. V11 said that it was only her second day working with R2 and her assignment sheet said that she was a one person assist. V11 said that she brought her into the shower room bathroom and put a gait belt on her and had her stand and hold onto the bar next to the toilet. V11 said that when she went to move her hands on the bar, R2 started screaming and becoming irrational. V11 said that she then put her arms around R2 and gave her a hug from behind her and slowly lowered her to the floor. V11 said that she heard after the incident that R2 was supposed to be a two person transfer. V11 said that she was the only staff member in the shower room at the time of the incident. R2's Kardex as of 2/3/25 shows, Transfer: needs total assist with transfers. The facility's Assessment, Documentation and Care Planning for Residents at Risk for Falls or Who Have Fallen Policy revised 7/19/24 shows, Fall prevention interventions will be developed, documented in the care plan, communicated to involved staff, and implemented based upon the assessment of resident- specific risk factors for falls.