

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145986	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/13/2025
NAME OF PROVIDER OR SUPPLIER  Lake Forest Place		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on interview and record review the facility failed to secure narcotic medication after delivery from the pharmacy. This applies to one of three residents (R1) in the sample of seven reviewed for medication storage. The findings include: The facility reported incident report dated 8/4/2025 shows a narcotic was delivered to the facility from the pharmacy on 8/2/2025 at 7:11 AM for R1. On 8/4/2025 the narcotics could not be located. The facility face sheet for R1 shows she was admitted to the facility after a stay in the hospital for pneumonia and respiratory failure. R1 had a Physicians order for hydrocodone (narcotic pain medication) to be used as needed for pain. R1 was discharged from the facility on 8/4/2025 as planned. On 8/13/2025 at 10:30 AM the door to the nursing station was locked. V7 Unit Secretary came and unlocked the door for this surveyor and said, It's locked today because the state is in the building. On 8/13/2025 at 10:01 AM, V3 Registered Nurse said she was the day shift supervisor working the morning of 8/2/2025 when the narcotic was delivered from the pharmacy. V3 said she was getting report, so the night shift supervisor (V4) took the narcotics from the pharmacy delivery driver. V3 said V4 should have delivered the narcotics to the nurse assigned to R1 that day so they could be secured in the narcotic lock box on the medication cart, but she put in a bin on top of the shredder in the nurses' station instead. V3 said she was very busy that day and never locked the narcotic medications up as they were supposed to be. V3 said when she left for the day, the narcotic was still in the bin on top of the shredder. On 8/13/2025 at 9:57 AM, a call placed with message left to V4 Registered Nurse (RN) was not returned. The undated facility interview with V4 shows she received the narcotic medication from the pharmacy on 8/2/2025 at 7:11 AM. V4 said she was very busy at the time so she put the medication on the medication tray inside the medication room and never signed in the narcotic or place the narcotic in a locked narcotic box. On 8/13/2025 at 12:17 PM V2 Director of Nursing said he became aware the narcotic for R1 was missing on 8/4/2025. V2 said he completed an investigation and could not determine what happened to the missing narcotic. V2 said he expects the nursing staff to immediately sign in narcotics when delivered from the pharmacy and deliver the narcotic to the assigned nurse so the narcotic can be locked up in the narcotic lock box of the medication cart. V2 said this is to ensure the narcotic is not lost or stolen. The pharmacy delivery invoice shows the narcotic for R1 was delivered and signed for by V4 on 8/2/2025 at 7:11 AM. The facility policy dated July 2024 for medication storage in the facility shows medications included in the Drug Enforcement Administration (DEA) classification as controlled substance are subject to special handling, storage, disposal and record keeping in the facility. Only authorized licensed nursing and pharmacy staff have access to controlled substances. Schedule 2 medications are stored in a permanently affixed, double locked compartment separate from all other medications. All controlled substances must be counted every shift.</p>		

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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