

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 01/28/2026
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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review the facility failed to ensure fall interventions were in place for a resident with a history of falls for 1 of 15 residents (R7) reviewed for safety in the sample of 15. The findings include: R7's Face Sheet printed on 1/26/26 listed a history of falling as a diagnosis. R7's Fall Care Plan with an initiated date of 7/7/24 showed R7 had fallen while at the facility and had a history of falling out of bed. Listed under interventions was the use a floor mattress. On 1/26/26 at 10:14 AM, R7 was in bed. There was no floor mattress on the floor next to R7's bed. The floor mattress was lying up against the wall near the head of the bed. There were no staff members, family, or care givers in the room. On 1/27/26 at 12:07 PM, V10 (Certified Nursing Assistant) said floor mattresses should be placed on the floor next to the bed when the resident is in bed.

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