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	04/23/2026

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 - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide adequate supervision and implement swallowing precautions for a resident at risk for choking for 1 of 3 residents (R1) reviewed for safety and supervision in the sample of 3.The findings include:On 4/23/26 at 9:37 AM, R1 was well-groomed, seated in his wheelchair in the foyer. R1 leaned to his right side, he was slow to respond, and had some drool in the right corner of his mouth. R1 said he had some trouble swallowing a few days ago. R1 said he was taking big bites and eating too fast. R1 said he couldn't catch his breath, and the staff had to help him. R1 stated, I wouldn't say they saved my life, but they helped. R1 said he was eating pureed food when he choked. At 12 PM, R1 was feeding himself pureed turkey chili, garden vegetables, corn bread, and fries with a spoon. V5 (Restorative Certified Nursing Assistant (CNA) was positioned next to R1, watching him. R1 attempted to take big bites and eat quickly. V5 provided verbal cues to take smaller bites and eat slower. The facility's Final Incident Report showed on 4/19/26 at 12 PM, R1 had a choking episode. This document showed R1 was alert and oriented x3 (to person, place, and time), was eating at the table in the dining room, and suddenly showed symptoms of a blocked airway witnessed by a CNA (V5). The CNA alerted the nursing supervisor. The nursing supervisor (V3) noted R1's face was turning red and lips to bluish color. The nurse supervisor performed two abdominal thrusts with a weak cough produced. The nurse supervisor gave three additional abdominal thrusts and pronounced cough and audible noises noted. No food particles came out of R1's mouth. R1 was able to talk and thanked the nurse. R1 was able to drink nectar thick liquids, had no adventitious lung sounds. The nurse called the Nurse Practitioner (NP) and orders were received for chest X-ray, NPO (nothing by mouth), Speech Therapy consult, IV (intravenous) fluids, and evaluation at the hospital. R1's wife was notified and refused NPO, hospital evaluation, and IV fluids. This document showed that Speech Therapy will talk to R1's wife/POA that choking episode cause was possibly progression of Parkinson's Disease. R1's Chest X-ray results showed, There is accentuation of the pulmonary vasculature with early interstitial infiltrates in both lung bases. Clinical correlation is requested. The lung fields are otherwise essentially clear.R1's Facesheet dated 4/23/26 showed diagnoses to include, but not limited to Parkinsonism, hypertension, wedge compression fracture of the thoracic vertebrae, anxiety disorder, insomnia, dysphagia (oropharyngeal phase), and dementia. R1's Speech Therapy Discharge summary dated [DATE] showed R1 demonstrated fluctuating cognition and the need for varying cues to implement safe swallowing strategies. The discharge recommendations showed close supervision for oral intake; cues for slow rate, small bites and sips; and cues for no talking while eating. R1's Speech Therapy Notes dated 4/20/26 showed he said he was eating too fast when the choking incident occurred. R1's Physician Order Sheet showed an order initiated 6/4/2025 for Swallow Guidelines. This order showed R1 should be seated upright at 90 degrees for correct positioning during food intake and 30 minutes after; alternate food and liquids; clear mouth before each next bite/sip; watch neck for swallowing; small bites/sips; slow rate; close supervision; and purred diet. R1's Nutrition Care Plan showed he was at risk for aspiration (choking) and R1's Swallow Guidelines dated (continued on next page)

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

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	04/23/2026

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 - Minimal harm or potential for actual harm Residents Affected - Few	10/31/25 included oral care 2-3 times per day; provide cues for small bites and to slow down as needed; no straw; upright seated at 90 degrees during food intake; alternate food and liquid; slow rate; no talking while eating; and within reach for physical and verbal cueing.On 4/23/26 at 9:39 AM, V4 (Restorative CNA) said R1 was able to feed himself but needed supervision. V4 said R1 sits at the guy's table, and he feeds one resident while supervising the other two. V4 said he was seated at the table with R1, feeding another resident. V4 said he was focused on the resident he was feeding and not watching R1. V4 said he wasn't sure if R1 was alternating bites of food with liquids, eating too fast, or taking big spoonfuls because he was focused on the resident he was feeding. V4 said he heard noises and looked to his side where R1 was seated. V4 said R1 was turning red, and it looked like he was trying to cough, but he couldn't. V4 said he yelled for the nurse and V3 (Nursing Supervisor) came over and performed abdominal thrusts. V4 said V3 was able to get R1 coughing and after that he was completely fine. V4 said R1 said he thought he was eating a sandwich and took a big spoonful. V4 said R1 does like to eat fast and tends to take big spoonfuls of his pureed food. V4 said R1 was eating purred food and didn't have access to any regular textured food. On 4/23/26 at 9:12 AM, V3 (Nursing Supervisor) said R1 was not on 1:1 feeding assistance, but we stay in the dining room with him. V3 said R1 was known to eat fast. V3 said R1 had a pureed diet in front of him and she thinks he had a pureed sandwich, vegetables, and something else. There were three pureed items on his plate. V3 said she was seated at another table with a resident that needed guidance and reminders. V3 said V4 called out that R1 was choking. V3 said she went right to R1. V3 said R1's face was beefy red and his lips were changing color. V3 said she asked R1 if he was okay and she could tell he was in trouble, so she did two abdominal thrusts. V3 said a faint sound of air moving was noted, but the color of his face hadn't changed. V3 said she gave three additional abdominal thrust and R1 started coughing and drooling. V3 said R1 didn't produce any food, but it looked like he swallowed. V3 said R1 was following instructions and was fine after the choking incident. V3 said R1's lung sounds were clear, his vital signs were stable, and he was pleasant with her after the incident. V3 said he was back to baseline. On 4/23/26 at 11:56 AM, V6 (CNA) said R1 can feed himself but needs to be supervised. V6 said she was at a different table with her back to R1, feeding another resident. V6 said V4 (Restorative CNA) said R1 was choking and V3 (Nursing Supervisor) went over right away and helped him. On 4/23/26 at 11:28 AM, V7 (Speech Therapist) said R1 had Parkinson's disease, and his swallowing ability and cognition fluctuate throughout the day and during a session. V7 said when R1 was discharged from Speech Therapy in October 2025, swallowing recommendations (or strategies) were provided to the nursing staff. V7 said she expects the staff to implement the recommendations made in the Discharge Summary. V7 said if the recommendations aren't followed it increases the risk of aspiration or choking. V7 said close supervision means someone should be sitting with the resident with their eyes on him. They should be watching, so they can provide appropriate reminders to R1. He inconsistently takes big bites and can eat fast at times. V7 said R1 is inconsistent with his presentation and willingness to follow directions. V7 said when she asked R1 what happened he said he ate too fast. On 4/23/26 at 10:18 AM, V2 (Director of Nursing - DON) said R1 had times where he's lucid and times where he was confused and hallucinating. V2 said R1 had some coughing during meals, but never choking like this episode. V2 said facility staff must remind R1 to eat food and alternate with drinks and remind him to slow down. V2 said R1 will [NAME] up the food quickly, and lave the dining room. V2 said close supervision means the staff have eyes on the R1. V2 said the staff need must watch the R1 closely to provide the appropriate cues. V2 said he expected the staff to follow the swallowing recommendations made by Speech Therapy. The facility's Assistance with Meals Policy dated 2001 showed, Residents shall receive assistance with meals in a manner that meets the individual needs of each resident.The facility's Meal Supervision and Assistance Policy dated 2025 showed, the facility will develop and implement an individualized care plan based on the Resident Assessment Instrument to address the resident's needs and goals, and to monitor the results of the planned interventions such as adequate supervision during meal time. Alternate food and liquids as needed to cleanse mouth of food.