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	12/12/2024

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34891 Based on observation, interview, and record review the facility failed to check placement of a feeding tube prior to administering a nutritional supplement for 1 of 1 resident (R25) reviewed for feeding tubes in the sample of 12. The findings include: R25's face sheet printed on 12/12/24 showed diagnoses including but not limited to Parkinson's disease, dysphagia (difficulty swallowing), dementia, epilepsy, and protein-calorie malnutrition. R25's facility assessment dated [DATE] showed severe cognitive impairment and the use of a G tube for nutrition (gastrostomy tube-soft, plastic feeding tube that goes into the stomach). R25's December 2024 order summary report showed an order start dated 7/2/24 for: .enteral feeding give 1 carton (237 milliliters) of Jevity 1.5 calorie at noon per G tube . The same report showed orders start dated 7/1/24 to check placement of the G tube before administering medication or feedings. On 12/11/24 at 1:27 PM, V9 (Registered Nurse) administered R25's enteral feeding while he was in bed. The end of the tube inserting into R25's stomach was covered with a white dressing and was not visible. V9 poured the liquid nutrition and water into a plastic beaker. V9 connected a plastic syringe to the end of the G tube and flushed the tube. V9 poured the liquids into the tube and flushed it again. V9 did not check placement of the tube prior to administering the feeding. At 1:45 PM, V9 stated she usually uses the aspiration method to check placement. She uses a stethoscope connected to the G tube and listens for a puff of air. V9 said she did not do it today because she did not have her stethoscope with her. V9 stated it is important the tube is in the right place, so the nutrition goes into the stomach. On 12/12/24 at 10:44 AM, V2 (Director of Nurses) stated nurses should be checking for placement using the aspiration method, residual method, or look for the mark on the tubing where it is inserted. They need to check placement prior to administering anything to reduce the danger of the tube having been dislodged. There is the potential for an infection in the abdominal wall if the tube is not in the right place. (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

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R25's care plan showed a focus area related to risk of aspiration pneumonia from the use of a feeding tube. Interventions included checking for placement and gastric contents/residual volume per facility protocol and record (start dated 10/14/24). The facility's Enteral Nutrition policy last review dated 3/31/24 states under the verifying placement of feeding tube section: 1. Tube placement is checked prior to administering medications tube flushes, or enteral formula.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 39537 Based on observation, interview, and record review the facility failed to ensure dishes were washed in a manner to prevent cross-contamination and failed store thickener in a manner to prevent cross-contamination. This affects all 44 residents residing in the facility. The findings include: The facility's CMS 671 Form dated 12/10/24 shoed there were 44 residents residing in the facility. 1. On 12/10/24 at 10:08 AM, the surveyor, V3 (Dietitian), V4 (Director of Dining Services), and V8 (Dietary Manager) returned to the main kitchen. The dishwashing area was inside the door, to the left. The dishwashing station was a small square shaped area, with an opening to enter the area. The dirty dishes were stacked to the left of the dishwasher and directly across the area, from the dishwasher. The clean dishes were removed from the right side of the dishwasher and stacked against the adjacent wall. The 3 compartment sink was positioned to the right of the clean dishes (or on the opposite wall from the dishwasher). The additional dirty dishes were stacked at the end of the 3 compartment sink. V5 (Dishwasher) applied green, rubber gloves that extended to his elbows. V5 sprayed food debris from a large, rectangular shaped plastic bin. The food debris and water sprayed back toward V5. V5 placed the plastic bin into the dishwasher and returned to spraying food debris from the dirty dishes. The dishwasher cycle completed and V5 moved directly from the dirty dishes to remove the clean, plastic bin and move it into the drying area. V5 did not remove the soiled gloves and he didn't not clean his hands. V5 moved back to the dirty dishes and continued to spray food debris from the mixing bowls and stainless steel containers. V3 (Dietitian) walked over to V5 and whispered to him. V5 stopped washing dishes. V4 (Director of Dining Services) tested the sanitizer levels of the 3 compartment sink and left the dishwashing area. V5 resumed spraying food debris from the dirty dishes. V5 placed a load of mixing bowls and stainless steel containers into the dishwasher and returned to spray food debris from the dirty dishes. When the dishwasher cycle was complete, V5 turned to the clean side of the dishwasher, removed the clean dishes, and stacked them in the drying area. V5 continued to wear the same green rubber gloves and didn't not wash his hands when moving from clean to dirty. V5 continued to move from clean to dirty and back to clean without washing his hands. V5 was observed until 10:17 AM. On 12/11/24 at 11:30 AM, V4 (Director of Dining Services) said she expects the dishwasher to scrub dishes and removed food debris and place the dishes in the dishwasher. V4 said if the dishwasher is moving from dirty dishes to clean dishes, then he should have washed his hands to prevent cross-contamination. V4 said he shouldn't have been going back and forth from clean to dirty without washing his hands. The facility's Hand Hygiene and Infection Control Policy revised 1/24 showed, In the Food & Nutrition Department: All associates associated with the handling of food shall wash hands. Hands are washed with soap and water and the following times: .Before handling food or clean utensils/dishes/equipment . Procedures: All Food Handlers: Use only sinks designated for hand washing . A Dishwashing Policy was requested and not received. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. On 12/11/25 at 9:19 AM, V6 (Cook) was in the rear station chopping raw vegetables. There was a small, clear plastic bin of thickener along the back of the counter. The container had a lid on it. A stainless steel measuring cup was half buried inside the thickener. The handle of the measuring cup was under a layer of thickener. V6 prepared the buttered carrot puree. V6 said the consistency was too thin and he would need to add thickener. V6 removed the lid to the thickener container, left the buried measuring cup in the thickener, and obtained a clean measuring cup to scoop thickener. V6 added the thickener to the carrots and left second measuring cup inside the thickener container. At 9:28 AM, V6 pureed the pork carnitas for the quesadilla. V6 said the puree was too thin and he needed to add some thickener. V6 removed the half buried, measuring cup from the thickener, and used the handle to scoop thickener. V6 added the thickener to the pork mixture and blended the food further. V6 returned the measuring cup to the container of thickener. The thickener now had 2 measuring cups sitting inside the container. On 12/11/24 at 11:30 AM, V4 (Director of Dining Services) said scoops or measuring cups shouldn't be stored in the thickener due to the risk of cross-contamination. V4 stated, They know better than that. The facility's Storage of Pots, Dishes, Flatware, Utensils Policy reviewed 1/23 showed, Procedure: Pots, dishes, and flatware are to be stored in such a way as to prevent contamination by splash, dust, pests, or other means. Procedures: Dish Handlers, Trayline Area Associates: .Store utensils vertically, in a bucket with handles pointing up, to reduce opportunities for contamination .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34891 Based on observation, interview, and record review the facility failed to ensure PPE (personal protective equipment) was worn in a manner to prevent cross contamination for 1 of 1 resident (R8) reviewed for infection control in the sample of 12. The findings include: On 12/10/24 at 11:19 AM, R8 had a PPE bin outside the door. There was a large sign on the door of the room that said, STOP Enhanced Barrier Precautions. The signage had illustrations to show gloves and gowns must be worn during high-contact resident care activities. The care activities included but were not limited to: dressing, transferring, and assisting with toileting when a urinary catheter was in use. This surveyor entered the room and R8 was standing at the sink while brushing his teeth. V11 (CNA-Certified Nurse Aide) was in the bathroom and wearing only gloves. V11 assisted R8 across the room using a gait belt and walker, then transferred him to an upright recliner. V11 emptied the garbage can and exited the room. V11 was not wearing a gown at any time during the care. R8 stated he has a catheter because he can't get to the toilet in time. R8 stated he needs help from the staff for all transfers and to get dressed. R8 stated V11 had just helped him use the toilet and put his pants on before this surveyor entered the room. R8 said staff usually wear gloves but do not always wear a gown when they empty his catheter or him use the toilet. R8's facility assessment dated [DATE] showed he was cognitively intact and the use of a urinary catheter. On 12/11/24 at 10:24 AM, V12 (Infection Control Preventionist) stated the enhanced barrier precaution signs show staff what they need to wear in the room. Residents with catheters have the precaution signs and PPE outside every room. Gowns and gloves should be worn during high-contact care which does include transferring, toileting, and dressing a resident. The PPE is important to help stop the transfer of germs from resident to resident. On 12/11/24 at 1:58 PM, V11 (CNA) stated she needs a gown and gloves on basically anytime she enters R8's room because he has a catheter. V12 said she did have a gown on yesterday during care but took it off while he was brushing his teeth. V12 said she should have still been wearing one while transferring him. On 12/12/24 at 10:39 AM, V2 (Director of Nurses) stated aides need to wear a gown and gloves when providing care to a resident with a catheter. Especially if they need to touch the lower part of the body. V2 said R8 is alert, oriented, and has no memory problems. V2 stated proper PPE is important in case urine splashes. It is an infection control issue. Urine on staff clothing can transfer microorganisms to other residents. The facility's Enhanced Barrier Precautions (EBP) policy last revision dated 9/3/24 states under the procedure section: 11. PPE, gloves and gowns, will be required for all staff providing high-contact care activities which include .dressing, transferring, providing hygiene, changing briefs or assisting with toileting. The policy listed the use of urinary catheters as an indication for the implementation of enhanced barrier precautions.