STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146165	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Admiral at the Lake, The	933 West Foster Avenue Chicago, IL 60640

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews, the facility failed to review and revise the comprehensive resident-centered care plan for one resident (R2) out of four residents reviewed for care plan revision. Findings Include: R2's Minimum Data Set (MDS) dated [DATE] shows he is cognitively impaired. R2's electronic medical record (EMR) revealed R2 was initially admitted to the facility on [DATE] and was [AGE] years old with diagnoses of, but not limited to unspecified fall, subsequent encounter, malignant neoplasm of bladder, heart failure, unspecified atrial fibrillation, hypertension, unsteadiness on feet, muscle weakness generalized, chronic kidney disease, diverticulitis of intestine with perforation and abscess with bleeding. On 6/3/25 at 3:30 PM, V2 (Director of Nursing/Fall Coordinator) stated she has been in the facility since August 2024, she collaborates with the care plan coordinator to update the care plan with new interventions to prevent further falls. On 6/4/25 at 2:44 PM, V2 state if a resident falls once that resident is at high risk for fall, R2 had two falls prior, so he is at high risk, and a resident centered care plan should be updated accordingly to prevent further falls. Surveyor showed V2 that R2's falls of 2/18/25 and 4/5/25 were both initiated on 6/2/25, she stated she expects the care plan coordinator to update but she is planning to review all care plans. On 6/4/25 at 12:15 PM, V14 (Minimum Data Set/MDS/Care Plan Coordinator) stated that she has been working in the facility since 2022, she does the care plan for the diagnoses, medications, readmission, admission, quarterly, significant change, and helps with the fall care plan. The purpose of care plan is to set goals for the resident and for the staff to know how to care for the resident. Care plan should be updated post fall with appropriate interventions, R2's care plan should have been updated with the interventions to prevent further fall. Documents reviewed are not limited to the following: R2' Face Sheet, POS, Section C, GG, and of MDS. R2's fall care plan was initiated on 6/2/25 for fall of 2/18/25 and 4/5/25. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Care Plan-Comprehensive Policy dated 1/2024, documents read in part: assessments of resident are ongoing, and care plans are revised as clinical information about the residents and if the residents' conditions change.

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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 0689 Level of Harm - 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 interview, and record review facility failed to perform accurate fall risk assessment for a resident with a known fall history, develop and implement post fall interventions to prevent future falls and failed to monitor, document, and send resident to hospital in a timely manner post fall incident for one resident (R2) out of four residents reviewed for accident and supervision. This failure led to R2 falling in the facility sustaining multiple acute fractures. Findings Include: R2's Minimum Data Set (MDS) dated [DATE] shows he is cognitively impaired. R2's electronic medical record (EMR) revealed R2 was initially admitted to the facility on [DATE] and was [AGE] years old with diagnoses of, but not limited to unspecified fall, subsequent encounter, malignant neoplasm of bladder, heart failure, unspecified atrial fibrillation, hypertension, unsteadiness on feet, muscle weakness generalized, chronic kidney disease, diverticulitis of intestine with perforation and abscess with bleeding. On 6/3/25 at 1:53 PM, via telephone interview, V11 (Licensed Practical Nurse/LPN) stated that he observed R2 in a sitting position on the floor in his room on 5/12/25 at about 1:15 AM, he denied pain, or hitting his head, the vital signs were stable, he is not aware that R2 was on Eliquis, but the doctor ordered lab and to monitor since he did not hit his head. V11 also stated that there should be seventy-two hours post fall documentation every shift to monitor the resident for any changes and to prevent medical complication, but he did not work with R2 after the incident. R2's fall investigation summary form documents At around 1:15 AM resident observed on the floor, sitting position, by the bedside and call light is within reach. Resident verbalized I lost my balance while trying to get out of bed. On 6/3/25 at 3:30 PM, V2 (Director of Nursing/Fall Coordinator) stated that she has been in the facility since August 2024, she completes the fall risk assessment based on the root cause of the fall and collaborate with the care plan coordinator to update the care plan with new interventions to prevent further falls. V2 also stated that there should be seventy-two hours post fall documentation every shift to monitor R2 for any changes, to provide timely care and to prevent complication. On 6/4/25 at 2:44 PM, V2 stated that R2 was sent to the hospital on 5/16/25 due to neck pain with diagnosis of multiple acute fracture, he is at high risk for fall due to the history of fall prior to admission because he had a fall on 2/18/25. The fall risk assessment of 3/5/25 shows a score of 65, and on 4/9/25 with a score of 80 shows that R2 continues to be at an increased high risk for falls. He should be accurately documented and care planned to prevent further falls, but the readmission falls risk assessment of 4/21/25 shows a score of 3 (low risk). V2 stated that R2 was not accurately assessed to prevent the fall of 5/12/25 which resulted to multiple neck fractures, and when fall risk assessment is not accurately done, appropriate intervention will not be in place and resident safety will be compromised. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	On 6/4/25 at 12:15 PM, V14 (Minimum Data Set/MDS/Care Plan Coordinator) stated that she has been working in the facility since 2022, she does the care plan for the diagnoses, medications, readmission, admission, quarterly, significant change, and helps with the fall care plan. The purpose of care plan is to set goals for the resident and for the staff to know how to care for the resident. Care plan should be updated post fall with appropriate interventions, R2 is at high risk for fall, his fall assessment should reflect high risk, inaccurate fall assessment will lead to ineffective care plan and potentially another falls. On 6/4/25 at 1:16 PM, V15 (Medical Director) stated that he has been taking care of R2 for two years, he was substantially getting weaker, dependent on staff for activity of daily living, he is at high risk for fall, he had a big fall on 4/5/25, and another fall on 5/12/25. R2 was on Eliquis but according to the nurse report R2 denied hitting his head so there was no need to send him to the hospital on 5/12/25, however it is his expectation that nurses will continue to monitor him every shift and document to rule out any complication. Documents reviewed but are not limited to the following: R2' Face Sheet, POS, Section C, GG, and of MDS. R2's progress notes document on 5/16/25 at 1:30PM care partner and (NOD-nurse on duty) were assisting the care, the resident was screaming when the resident was moving in bed. (Physician) notified, per MD send (R2) out for further evaluation. Resident admitted with diagnosis of multiple acute fracture at C4, C5 and C6. R2's clinical records had no documentation showing that 72 hours post fall monitoring/supervision was done post fall of 5/12/25. R2's Fall risk assessment dated [DATE] with a score of 65 = high risk R2's Fall risk assessment dated [DATE] with a score of 80 =high risk R2' Fall risk assessment dated [DATE] with a score of 3 =low risk. Safety and supervision of residents' policy dated 12/2024, documents read in part: Resident supervision is a core component of the systems approach to safety. Fall Risk Prevention Policy dated 4/4/2025, documents read in part: Staff will try attempt interventions, based on the assessment.