STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145235	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakefront Nursing & Rehab Ctr	7618 North Sheridan Road Chicago, IL 60626

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44314 Based on interview and record review, facility failed to protect a resident from physical abuse. This failure affected one resident (R2) of seven residents reviewed for abuse. This failure resulted in R2 and R3 having a physical altercation, resulting in R2 bleeding from a scrape R2 sustained above the right eyebrow. Findings include: Facility's Investigation Report (dated 09/06/2024) notes: On 09/01/2024, at approximately 12:30 PM, R2 and R3 got into a verbal disagreement that resulted in a scuffle. Security immediately intervened and successfully separated both parties. An in-depth investigation was conducted which included staff and resident interviews. R3 was offered a beverage from a staff member. R3 declined which is when R2 chimed in strongly insisting that he accept the beverage. As both residents continued to disagree on the situation they became increasingly agitated with the situation to the point where R2 began to walk into R3's personal space. That is when R3 put out his arms to establish a personal space boundary. When this action took place, he made contact with R2. The assistant administrator interviewed both residents and both of them admitted that things got out of hand, and they did not mean for the situation to escalate. They both were able to identify other methods of handling the situation and agreed to utilize them if they are in a similar situation in the future. Abuse and Neglect Policy (date revised 07/12/2024) notes in part: It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect or mistreatment. Resident Rights Policy (undated) notes in part: You must not be abused by anyone-physically, verbally, mentally, financially or sexually. R2's Face Sheet documents resident is a [AGE] year-old with diagnoses including but not limited to: Generalized anxiety disorder, insomnia, unspecified, type 2 diabetes mellitus with ketoacidosis without coma, chronic obstructive pulmonary disease, unspecified, hyperlipidemia, unspecified, hypothyroidism, unspecified, other chronic pain. Minimum Date Set (MDS) section C (dated Sep.30, 2024) documents that R2 has a BIMS score of 15, indicating that R2's cognition is intact. (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
	145235	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakefront Nursing & Rehab Ctr	7618 North Sheridan Road Chicago, IL 60626

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Care plan (dated 10/02/2024) documents that R2 is at risk for falls due to decrease functional mobility and poor safety awareness. R3's Face Sheet documents resident is a [AGE] year-old with diagnoses including but not limited to: Hypertensive heart disease, with heart failure, generalized anxiety disorder, paranoid schizophrenia, major depressive disorder, schizoaffective disorder, bipolar type, hyperlipidemia, unspecified, heart failure, unspecified. Minimum Date Set (MDS) section C ([DATE]) documents that R3 has a BIMS score of 15, indicating that R3's cognition is intact. Care plan (dated 10/8/2024) documents that R3 uses psychotropic medication and at risk for possible drug reactions dizziness, headache, drowsiness, sedation, hypotension, tremors, poor coordination, impaired balance, constipation, insomnia, tardive dyskinesia and dry mouth. Care plan (dated 11/12/2024) documents that R3 demonstrates behavioral distress, being challenged by mental illness, ineffective coping mechanisms, physically aggressive behavior when agitated. On 11/12/2024, at 11:36 AM, surveyor interviewed R3 regarding the physical altercation that occurred between R2 and R3 on 09/01/2024. The interview took place in R3's room on the 3rd floor. R3 stated, My family is from Virginia, and I have family in North Carolina. I believe in Jehovah, and I follow his laws. The sister (R2) from the second floor was coming on to me and I had to turn it down in the name of Jehovah. R2 said to me that she wanted to make passionate love to me all night long. There was no argument that took place with R2. R2 thought I was born in [NAME], and this is a crazy world. There was no argument, I'm from Virginia and [NAME]. I read several different Bibles and many of them are not true. Jehovah's name was taken out of the Bible. R2 found out that she was my family, and she was still hitting on me. Making love to R2 would be considered incest and I rejected her in the name of Jehovah because R2 is my immediate family. R2 was disappointed but I said no. There was no physical argument or verbal argument that took place between R2 and I that I remember. On 11/12/2024, at 11:54 AM, surveyor interviewed R2 regarding the physical altercation that occurred between R2 and R3 on the date of 09/01/2024. The interview took place in R2's room on the 2nd floor. R2 stated, The incident happened in the hallway. I finished by meal. I went to the hallway to put my tray on the cart and after that I was going to go to my boyfriend's room. R3 was residing on the 2nd floor at the time. While I was in the hallway, R3 was talking to me. At that time, the housekeeper offered R3 a soda pop, and he refused it. R3 started talking to me and the housekeeper in a crazy way. R3 pushed me and my head hit the doorway and I fell . After that, R3 kept hitting me and he beat my a**, while the staff kept watching. R3 was beating me and one of the certified nursing assistants came and separated us. I was bleeding; my face was leaking bad. The security guy from downstairs also came and separated us too. As long as R3 is not on the same floor as me, I feel safe here. I'm a woman and I didn't put my hands on him and R3 kept beating me. They separated us and they sent me to the hospital to get checked out and they also sent R3 to the hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145235	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakefront Nursing & Rehab Ctr	7618 North Sheridan Road Chicago, IL 60626

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/2024, at 2:01 PM, V8 (Psychiatric Rehabilitation Services Coordinator) stated, I was not there the day that the incident between R2 and R3 took place. I know that there was an altercation between the two of them and that R3 was evaluated for his behavior. When R3 returned from the hospital, we made sure that R3 is placed on a different floor away from R2. R3 is not historically an aggressive resident. R3 is not a good historian. R3 is very tangential and has a flight of ideas and he goes all over the place. R3's baseline is pretty delusional. R3's standard frame of mind is that he has delusions on everyday basis. R3 is not known to be aggressive, he is mostly in his own world. R3 likes to keep to himself. R2 is friendly and non-aggressive towards anyone. R3 has never had any issues with fighting with anyone since she has been to the facility. On 11/12/2024, at 2:25 PM, V1 (Administrator) stated, I am the Abuse Prevention Coordinator. The residents have the right to be free from abuse, comfortable and feeling like they are at home. The incident between R2 and R3 was a quick encounter that started as a verbal disagreement that turned physical. I believe that the altercation stared as a verbal argument over a pop that was being offered to R3. R3 was also a newer resident to the facility at the time of the altercation. I believe a staff member offered R3 a soda pop. I believe it was a housekeeper who might have offered R3 a pop. That's when R2 interfered with R3 and said to R3 that he should take the pop. From that point, per the investigation, R2 and R3 got into a disagreement over the soda pop. R2 approached R3 and kept getting closer to R3's face. R2 was the aggressor not R3. At that point when R2 got closer to R3's personal space, that's when it turned into a scuffle. The way it was explained to me is that R3 put his arm out to push R2 away from R3, to defend himself and to move R2 away from his personal space. That's when R2 fell . Staff called a code gray right away when R2 fell to the ground. The housekeeper saw the whole incident. The 2 residents were immediately separated. R3 walked away and went into his room. R2 kept trying to go after R3. R2 was more of the aggressor and R2 kept trying to look for assistive devices to hit R3 with. R3 was placed on a 1 to 1 supervision. R2 was also placed on 1 to 1 supervision because she was the aggressor and not R3. R3 is not a resident who bothers other residents. R3 is calm and keeps to himself. R2 was placed on staff supervision because she would not stop going after R3. R2 was so agitated that R2 would not stop going after R3, and R2 had to be sent out. R2 was on the floor because she fell . R2 had to be sent out to get medically checked out and because R2 was aggressive. She needed a psychiatric evaluation. When I investigated this incident, I did not substantiate the incident because it was a behavior. The incident was sparked by R2 and led to R3 also having behaviors. Both residents were separated and kept safe and R3 was moved to a different floor. On 11/13/2024, at 10:26 AM, V11 (Registered Nurse) stated, I am familiar with the incident that took place on 09/01/2024, between R2 and R3. I was working on the 1st floor that day, and the incident took place on the 2nd floor. They called a code gray (fight between residents), and I went to the 2nd floor to respond to the code. When I got to the second floor, I saw that the CNAs (Certified Nursing Assistants) escort R2 back to her room. I did not get a chance to assess the situation because there was a nurse present on the floor and the residents were already separated and I went back downstairs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145235	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakefront Nursing & Rehab Ctr	7618 North Sheridan Road Chicago, IL 60626

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/2024, at 11:37 AM, V12 (Assistant Administrator) stated, On 09/01/2024, I received the initial report that an incident took place between R2 and R3. I proceeded to investigate and ask questions of what took place. I asked the security guard what happened, and I got his statement. I also got the statement from the CNAs and the nurses that were there. From getting the statement, what basically happened is that R3 was offered a soda pop on the second floor. R3 refused the soda pop and that's when R2 put in her two sense and just started telling R3 to just take the pop. As R2 chimed in and started telling R3 to take the pop, R2 was walking towards R3, and that's when R3 put out his hand to protect himself, to establish his personal boundary or his personal space, and that's when the contact happened between R2 and R3. As R3 put out his hand to protect his personal space from R2, I do not recall anybody telling me that R2 fell . R2 did not tell me that she fell when R3 put out his hand to establish his personal space. Staff separated the 2 residents to prevent any further escalation and both residents were placed on 1 to 1 monitoring. The physicians were called and notified, and orders were given to send both residents to the hospital for evaluations. R3 was admitted to the hospital and R2 returned to the facility with no new orders. At the time of the initial report, it was believed that R3 was the aggressor, but in reality, after the investigation was done it was actually R2 who instigated the incident. R2 said to me that R2 should not have put her two cents in when R3 refused the soda. R2 was very remorseful about butting into other people's business. Nobody was the aggressor, because it was not abuse, it was just an incident that unfortunately escalated more than it should have. There was no maliciousness and no intent for abuse. R2 admitted that R3 was putting up his hands to establish his boundary. R2 admitted that when R2 talks to others, she has a tendency to walk towards that person, and R3 misunderstood that that's why he put his hand up as a boundary. On 11/13/2024, at 12:15 PM, V13 (Certified Nursing Assistant) stated, What happened is that day I worked the 7:00 AM to 3:00 PM shift. I was sitting at the nursing station trying to do my documentation on the computer and I heard the noise. I did not know what the noise was. I got up from the chair and I went to the hallway, and I saw both residents, R2 and R3, fighting each other physically. I ran to them and I immediate separated both the residents. I moved R3 to his room and I closed the door so that he is away from R2. R2 was in the hallway. I saw R2 hitting R3 and R3 was hitting R2. They were both physically fighting each other. It looked like R3 had the upper hand above R2 during the fight. I did not see R2 on the floor. I saw R2 lose balance and I saw R2 struggling because R3 had the upper hand during the fight. The code was called, but the residents were separated by me before anyone else arrived. When I saw the residents fighting each other, I moved R3 away from R2. I did not see R2 on the floor, but I saw R2 get hit and I saw R2 hitting R3 as well. I separated the 2 residents immediately and made sure that they are both safe and R3 was in his room with the door closed while the code was called. R2's Progress Notes (dated 09/01/2024) documents, Resident back From ER after evaluation done and found stable condition. Follow up with primary DR. within 3 days. R2's Progress Notes (dated 09/01/2024) documents, Resident on 1-1 ongoing observation. R2's emergency room Record (dated 09/01/2024) documents in part, Patient states she resides in a nursing home, today she reports she was involved in a physical altercation. Patient reports she obtained trauma to the head and chest. States she has pain in the back of her neck, in the chest where she states she was hit and her face. Physical Exam- Head: normocephalic, scrape over right eyebrow. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145235	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakefront Nursing & Rehab Ctr	7618 North Sheridan Road Chicago, IL 60626

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's Progress Notes (dated 09/02/2024) documents, Resident is admitted at community hospital for aggressive behavior as per nurse on duty. Called emergency guardian at 6:40 AM with no answer and message cannot be left. The answering machine stated to call back during regular hours.