STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014377	A. BUILDING: _____ B. WING _____	C 09/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY ESTATES OF LINCOLNSHIRE	150 JAMESTOWN LANE LINCOLNSHIRE, IL 60069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation 2417115 /IL177640	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) 300.1210d)3)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014377	A. BUILDING: _____ B. WING _____	C 09/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY ESTATES OF LINCOLNSHIRE	150 JAMESTOWN LANE LINCOLNSHIRE, IL 60069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 1	S9999		

and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014377	A. BUILDING: _____ B. WING _____	C 09/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY ESTATES OF LINCOLNSHIRE	150 JAMESTOWN LANE LINCOLNSHIRE, IL 60069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 2	S9999		

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to identify and assess a resident experiencing a change in condition. This failure resulted in a delay in treatment for R1, and R1 experiencing pain due to fractured hip for 1 of 3 residents (R1) reviewed for falls in the sample of 9.

Findings include:

R1's Admission Record, printed by the facility on 9/6/24, showed he had diagnoses including Alzheimer's disease, anxiety disorder, depression, osteoarthritis of knee, restlessness and agitation, weakness, and a history of falling. R1's facility assessment dated 8/22/24 showed he had wandering behaviors daily. The assessment showed R1 required supervision or touching assistance for walking 50 feet with two turns, and partial/moderate assistance for walking 150 feet. The assessment showed R1 was frequently incontinent of urine, and occasionally incontinent of bowel. The assessment showed R1 was unable to answer when asked if he had pain or hurting at any time in the last 5 days of the assessment. The assessment also showed R1 had a fall within two-to-six months prior to admission. R1's care plan initiated on 9/4/24 (after being discharged to a local hospital) showed he demonstrates having a cognitive impairment relate to diagnosis of Alzheimer's disease or other form of dementia. R1's care plan initiated on 8/26/24 showed he had an ADL (activities of daily living) self-care performance deficit related to Alzheimer's disease, restlessness and agitation, weakness, history of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014377	A. BUILDING: _____ B. WING _____	C 09/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY ESTATES OF LINCOLNSHIRE	150 JAMESTOWN LANE LINCOLNSHIRE, IL 60069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 3	S9999		

fall, and osteoarthritis. R1's care plan initiated on 9/4/24 (after admission to a local hospital) showed he had a behavior of wandering into other patients' rooms and taking others' belongings. The care plan showed R1 was usually easy to redirect but has in the past exhibited aggression and non-compliance with redirection. R1's Wandering care plan (initiated on 9/4/24-after being admitted to the hospital) showed R1 had current behaviors of pacing, roaming or wandering in and out of peers' rooms. R1's 8/20/24 care plan showed he is a high risk for falls.

R1's Progress Note, written by V9 on 9/2/24 at 10:47 PM, showed Fall f/u (follow-up) . Resident is responsive and alert to baseline with no change of condition noted. All medication given as schedule. Neuro-check in progress.

On 9/5/24 at 7:55 AM, V18 (R1's daughter) said R1 was admitted to the facility on 8/16/24. V18 said R1 had a fall in the facility and was diagnosed with a hip fracture. V18 said R1 had hip surgery on 9/4/24. V18 said V19 was R1's Power of Attorney (POA) and she went into the facility often to see R1.

On 9/5/24 at 6:28 PM, V19 said she had been in the facility literally every day to see R1 except on 9/2/24 because she was taking a family member to the airport. V19 said R1 had a fall on 8/30/24 and another fall on 9/2/24. V19 said she received the call on 9/2/24 that R1 had fallen. V19 said she called V4 (Hospice Registered Nurse-RN) and V4 said she would go in and check on R1. V19 said V4 went into the facility and did not see any apparent injury on R1 at the time of her assessment. V19 said early Tuesday morning, around 6:45 AM, she received a call from V10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014377	A. BUILDING: _____ B. WING _____	C 09/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY ESTATES OF LINCOLNSHIRE	150 JAMESTOWN LANE LINCOLNSHIRE, IL 60069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 4	S9999		

(RN) saying that R1 was grimacing, and his knee may be swollen. V19 said she got to the facility around 7:15 AM and told the nurse to call an ambulance. V19 said R1 was in excruciating pain and kept saying "Too much pain. Too much pain" in his native tongue.

On 9/6/24 at 11:38 AM, V4 (Hospice RN) said she was the on-call hospice nurse. V4 said she went into the facility around 11:30 AM to check on R1. V4 said R1 was standing up in the middle of the room when she got there. V4 said R1 was confused and weak so she helped him sit down in a chair. V4 said she and one of the CNAs transferred R1 into bed and provided incontinent care. V4 said she did not see R1 show any signs of pain or discomfort while they were providing care.

On 9/6/24 at 11:42 AM, V7 (Licensed Practical Nurse-LPN) said she had just started her shift on 9/3/24 and she saw V19 in the facility. V7 said she asked V19 why she was there so early. V7 said V19 told her that she was called and told R1 was not doing well. V7 said she got shift report from V10 (RN) the overnight nurse. V7 said V10 informed her (V7) that R1 had fallen on 9/2/24 at 5:00 AM. V7 said V10 told her R1 was in a lot of pain, so she called V19 (R1's POA). V7 said V19 came out and told staff that R1 was wet so V7 said she called the CNA. V7 said V19 came back out of R1's room and said he cannot move. V7 said she and V19 both called hospice to let them know, then V7 said she went in to assess R1. V7 said she noticed one of R1's legs were shorter than the other. V7 said R1 was sent out to the hospital. V7 said V11 called her on Tuesday night and asked what happened with R1. V2 said she called V8 (Certified Nursing Assistant-CNA) and asked her how R1 was on second shift on 9/2/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014377	A. BUILDING: _____ B. WING _____	C 09/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY ESTATES OF LINCOLNSHIRE	150 JAMESTOWN LANE LINCOLNSHIRE, IL 60069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 5	S9999		

V2 said V8 told her that she informed V9 (LPN on duty on the second shift on 9/2/24) about R1's pain and that something was not right with R1.

On 9/6/24 at 12:18 PM, V8 (CNA) said she worked from 3:00 PM-11:00 PM on 9/2/24. V8 said when she started her shift she asked where R1 was and was told he was in bed, and he slept a lot during first shift. V8 said when she went to take R1 his dinner tray, she saw him in a wheelchair. She asked V23 (CNA) about R1 being in a wheelchair and V23 told V8 she and V9 put R1 in the wheelchair. V8 said she saw R1 trying to get up out of the wheelchair around dinner, and he made a face like he was in pain. V8 said she told V9 that she needed to do something because R1 was in pain, and he was not acting like his normal self. V8 said V9 told her she had just given R1 his pain medications. V8 said around 8:00 PM she put R1 back in bed. Around 9:30 PM R1 was trying to get out of bed so she and V9 put him back in the wheelchair. V8 said she told the oncoming CNA during shift change that R1 had been in pain and V9 had given him something for pain.

On 9/6/24 at 1:30 PM, V9 (LPN) said she worked from 3:00 PM-11:00 PM on 9/2/24. V9 said R1 was sleeping when she started her shift. V9 said some time before supper R1 got up and went into another resident's room. V9 said she told one of the CNAs to grab a wheelchair and put him in it because R1 was a fall risk, and had a fall that morning. V9 said staff had been monitoring R1 throughout the shift. V9 said staff would tell R1 to sit down when he tried to stand up from the wheelchair. V9 said R1 usually complained of pain to his knee. V9 said R1 just points to his area of pain, or you see it on his face, or he will touch his knee. V9 said R1 was showing signs of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014377	A. BUILDING: _____ B. WING _____	C 09/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY ESTATES OF LINCOLNSHIRE	150 JAMESTOWN LANE LINCOLNSHIRE, IL 60069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 6	S9999		

pain, so she gave him Tylenol. V9 said at one point after dinner, V8 told her that she thinks R1 was in pain. V9 said she told V8 that she had already given R1 some pain pills and she thinks he will be okay. V9 said she told V8 to just keep an eye on him. V9 said she did the neurological checks, level of consciousness and vitals on R1 per protocol. V9 said she informed the oncoming nurse (V10) that R1 had a fall, and he was being monitored and neurological checks were being done. V9 said she informed V10 that she had given R1 Tylenol for pain. V9 said she did not update R1's doctor because he was on hospice and the hospice nurse had evaluated him earlier that day.

On 9/6/24 at 1:54 PM, V10 (RN) said she worked from 11:00 PM on 9/2/24-7:00 AM on 9/3/24. V10 said R1 was up in a wheelchair when her shift started. V10 said she was told that R1 did not want to stay in bed. V10 said she told V24 (CNA-agency staff) to stay with R1. V10 said R1 would stand up and then sit back down, then stand up. V10 said R1 really did not walk around on the overnight shift. V10 said R1 did not show any signs of pain at that time. V10 said about 4:30 AM, V24 said R1 was sleepy so V24 and V10 put R1 in bed. V10 said when they put R1 in bed he was grimacing, grabbing his left leg, and guarding it. V10 said she assessed R1's left leg and it was a little swollen at his knee. V10 said R1's left knee was bigger than his right. V10 said she gave R1 medicine for pain and about 45 minutes later, R1 was still grabbing his leg and grimacing so she called hospice and left a message to return her call. V10 said she called V19 and V19 said she was coming to the facility. V10 said she asked V19 if she wanted to send R1 out to the hospital and V19 said she was waiting for hospice to call her back and was going to talk

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014377	A. BUILDING: _____ B. WING _____	C 09/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY ESTATES OF LINCOLNSHIRE	150 JAMESTOWN LANE LINCOLNSHIRE, IL 60069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 7	S9999		

to her sister. V10 said it was about shift change when V19 said she talked to hospice and wanted him to be sent out to the hospital. V10 said she did not notice any signs of increased pain prior to putting R1 in bed when he was grimacing and guarding his left leg.

On 9/6/24 at 3:13 PM, V11 (LPN) said on 9/3/24 he worked 7:00 AM-11:00 PM. V11 said V7 (LPN) called him to let him know she was sending R1 out. V11 said he told her she would have to call the Nurse Supervisor. V11 said he told V9 that he would help her get the paperwork ready to send R1 out. V11 said V2 (DON) went to him and told him to write pain assessments and other documentation and he (V11) told V2 no that he cannot do that because he did not want to put his license on the line. V11 said "Why should I lie because there wasn't a proper assessment." V11 said he did not observe R1 at all on the morning of 9/3/24.

On 9/7/24 at 1:42 PM, V3 (Nurse Practitioner) said if a resident has a fall with no injuries, staff should do post-fall monitoring. V3 said if there are any changes in the resident's pain and behavior changes-not being themselves, she would expect the nurse to do a full assessment and update her right away so they can determine what to do moving forward.

On 9/7/24 at 1:50 AM, V2 (DON) said if a resident has a change in condition, a change in behavior or shows signs of pain after a fall, the nurse on duty should do a thorough assessment and notify the resident's doctor or nurse practitioner to update them on the resident and see if they want the resident sent out to the emergency room for evaluation. At 2:28 PM, V2 denied asking any nurses to document assessments for R1 after he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014377	A. BUILDING: _____ B. WING _____	C 09/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY ESTATES OF LINCOLNSHIRE	150 JAMESTOWN LANE LINCOLNSHIRE, IL 60069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 8	S9999		

was sent out to the hospital.

The facility's policy and procedure titled Falls Policy and Procedure, with a revision date of 2/2/24, showed Fall Management: Nursing administration reviews every fall that occurs within the last 24 hours during the morning report meeting. Assessments of resident who is on the floor to include neurological signs, vital signs, and range of motion. Any suspected injury: Do a complete assessment identifying any deficits, deformities, pain and notify MD (doctor). Follow MD order which may include sending to ER (emergency room) or getting an in-house X-ray. Document findings. Protocol for any Unwitnessed Fall: Full assessment by the licensed nurse including vital signs and neurological vital signs for 72 hours, and range of motion assessment.

The facility's policy and procedure titled Management of Pain, with a revision date of 3/20/24, showed Physician Communication and Involvement: Pain will be assessed and managed in a timely fashion, especially if it is of recent onset. The physician will be notified of resident's complaint of pain when not relieved by medication as ordered by the physician. Thorough communication with the physician will ensure an appropriate pain management plan...Nursing Observation: Nursing observation is an important part of the pain assessment, especially in the non-verbal resident. Nursing will observe behaviors that may indicate pain in the non-verbal or cognitively impaired resident. Pain may be indicated when there are changes in the following: Facial expressions, vocal behaviors, body movements, routines, and mental status.

(A)