STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146028	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Serenity Estates of Lincolnshire	150 Jamestown Lane Lincolnshire, IL 60069

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 35178 Based on observation, interview, and record review the facility failed to consistently implement treatments and assessments for R3's Left Ventricular Assistive Device (LVAD) for 1 of 2 residents (R3) reviewed for quality of care in the sample of nine. The finding include: On 04/16/25 at 10:10AM, R3 was lying in bed. R3 had an undated 4 inch by 4-inch gauze dressing covered with a clear dressing to the right abdominal area. On 04/16/25 at 10:10AM, R3 said, this is the worst place I have ever been. I just got out of the hospital. I was in pain and I had to call 911 to get transported to the hospital. The LVAD Coordinator at the hospital took pictures of my dressing because it was so dirty. My LVAD dressing is supposed to be changed every day. On 04/16/25 at 11:10AM, V8 Licensed Practical Nurse (LPN) said, he (R3) went out on Saturday, they sent out a new order for the dressing to be changed every other day. I got the order from the nurse at the hospital verbally. On 04/16/25 at 11:51AM, V9 Nurse Practitioner (NP) said, R3's LVAD orders are managed by the LVAD clinic. R3 has a history of LVAD infection. The dressing prevents infection. On 04/16/25 at 11:55AM, V2 Director of Nursing (DON) said, the receiving nurse in the facility will review the orders from the hospital and reports to physician. The physician will tell us to go with the recommendation from the hospital, especially with LVAD, the physician will go with the LVAD clinic's recommendations. On 04/16/25 at 12:20PM, V8 LPN said, I use the dry kit for R3's dressing change. On 04/16/25 at 1:15PM, V2 DON said, there are no wet dressing kits on the floor. I have a few wet dressing kits in my office left over from a previous resident that has been discharged . The wet dressing kits have saline in them. If we need a wet kit we can just add the saline. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/17/25 at 11:32AM, V19 Registered Nurse (RN) said, when R3 arrived to me on April 13, 2025, the first thing I noticed was the dry dressing dated April 1, 2025; that is 11 days without a dressing change. R3 has an infection to the drive line of his implanted device. The drive line is the surgical insertion site through the skin. When an infection is present a wet dressing kit with daily dressing change is needed. The wet kit uses an anti-microbial soap to assist with clearing up the infections. The dressing is to keep the area clean and intact. If the dressing change is not performed it puts R3 at risk for infection. R3 was sent to the hospital with the main complaint of abdominal pain. After I changed the dressing R3 had immediate relief of pain. If the facility did not have the wet kits for R3 they should have contacted us or their suppler to provide them. R3 also reported to me the facility was performing blood pressures with an automatic blood pressure machine. R3 must have a manual blood pressure taken. The automatic machine cannot provide an accurate blood pressure due to R3's condition. V10 Clinical Nurse Specialist (CNS) is authorized to write orders for our patients. R3's Progress Notes dated 04/13/25 at 11:38AM, shows, admitted to Hospital Diagnosis abdominal pain. R3's LVAD Order dated 03/14/25 by V10 Clinical Nurse Specialist (CNS) shows, check vital signs and VAD readings once a shift. Calculate Mean Arterial Pressure (MAP) with every blood pressure check. Report MAP greater than 60 millimeters of mercury or greater than 90 millimeters of mercury on 2 separate readings checked 30 minutes apart. WOUND CARE: 1. Type of sterile driveline dressing change: Sterile wet kit. 2. Frequency of sterile driveline dressing change: Daily. R3's Treatment Administration Record dated March 2025 shows, R3's LVAD dressing was not changed on 03/19/25, 03/21/25, 03/22/25, 03/23/25, 03/24/25, 03/26/25, 03/27/25, 03/28/25, 03/29/25, 03/30/25, or 03/31/25. R3's LVAD Monitoring settings every shift for monitoring, has areas to document the device settings and the resident's Mean Arterial Pressure, dated March 2025 shows, R3 was not monitored: 03/18/25 on the day shift, 03/21/25 day and night shift, 03/22/25 day shift, 03/23/25 day shift, 03/27/25 day and evening shift, 03/29/25 day shift, 03/30/25 day shift and night shift. The facility Left Ventricular Assist Device policy dated 10/23/2024 shows, the nurse will obtain and verify the physician's order for the use to include the settings, care of the LVAD, and the contact information of the physician or clinic overseeing the LVAD. Vital signs will be obtained as ordered.

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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** 34117 Based on observation, interview, and record review the facility failed to ensure a resident who is a high risk for falls was supervised and failed to ensure fall interventions were individualized for a resident with poor safety awareness and cognitive deficits and failed to ensure bed rails were installed in manner to prevent entrapment. This failure resulted in R1 being found in her room kneeling on the floor with her right arm trapped between the side rail and the mattress sustaining a right comminuted humerus fracture. This applies to 1 of 3 resident (R1) reviewed for safety in the sample of 9. The findings include: R1's Final Incident Report dated 4/15/25 shows on 4/10/25 (R1) is a [AGE] year-old female with diagnoses including atrial fibrillation, type 2 diabetes, major depressive disorder, insomnia, hypertension, and dementia with agitation .(R1) usually transfers with partial to moderate one staff assist and can use call to alert staff when assistance is needed. (R1's) call light was activated, and the nurse (V3-Licensed Practical Nurse-LPN) responded to the light. (R1) was observed kneeling on the floor next to her bed with the wheelchair behind her. (R1's) right arm was between the side rail and the mattress and (R1) was complaining of pain to the right shoulder .(R1) was sent to the local hospital and admitted with diagnosis of right humerus fracture. On 4/16/25 at 9:45 AM, R1's bed was observed with two 1/2 side rails in an upright position. There was a gap (wide enough for her arm to fall through to get trapped) between the mattress and the side rail. On 4/16/25 at 11:53 AM, V3 (Licensed Practical Nurse-LPN) said on 4/10/25, she did not see R1 go back to her room after dinner. She heard R1 was yelling help me, help me and the call light alarming from the room. When she entered the room R1 was on her knees with her wheelchair behind her, her right arm was stuck between the mattress and the side rail. R1's 1/2 side rail was in the upright position, and she was complaining of pain to her right arm and she could not move her right arm. She asked R1 what happened and R1 could not tell her what happened. V3 said it looked like R1 slide from the bed or was transferring to the bed. R1 was having problems moving her right arm and she was transferred to the local hospital. We remind R1 to use her call light, but she likes to be independent. R1 does not need assistance with transfers and can transfer herself. R4 (R1's roommate) had activated the call light not R1, when she entered the room R4's call light was alarming. Frequent monitoring and supervision could have prevented the incident with R1. On 4/16/25 at 11:41 AM, V4 (Certified Nursing Assistant-CNA) said on 4/10/25, after passing the meal trays, she went to another resident's room to assist with feeding. V3 (LPN) reported she needed help with R1. When she entered R1's room she saw her kneeling on the floor, her right arm was stuck between the side rail and mattress, and she could not move her arm. She was saying, help me, help me. R1's call light was not activated, her roommate R4's call light was alarming. R1 never calls for help, she transfers herself, and does not staff assistance with transfers. She is not a fall risk. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/16/25 at 12:12 PM, R4 (R1's roommate) said on 4/10/25, she heard R1 fall but did not see what happened because the privacy curtain was pulled. R1 was yelling out so loud and she alerted the call light. On 4/16/25 at 10:18 AM, V5 (Registered Nurse-RN) said he is the nurse on this unit and splits between two units and so does the CNA. R1 is alert and forgetful, she self-propels in her wheelchair. We remind her to use her call light, but she does not remember to use it and he is not sure if R1 knows how to use the call light. She forgets where her room is and asks the same question over and over again. She tries to stand and self-transfer and forgets she needs assistance. She does not use her call light for assistance, she needs to be supervised. If she is left alone, she will attempt to get up. On 4/16/25 at 10:22 AM, V6 (CNA) said R1 is alert to self, but forgetful. We tell her to use her call light, but she does not use her light for assistance. R1 is one-person extensive assist, she is weak and does not ambulate. We toilet her after meals and lay her down. On 4/16/26 at 3:02 PM, V2 (Director of Nursing-DON) said R1 is high fall risk, she has alert and forgetful and reports her needs to staff. Staff reported R1 she can safely transfer herself and she is not sure if consents need to be obtained for the use of side rails. R1's X-ray report dated 4/10/25 shows comminuted fracture (a bone broken in at least two places) of the right humeral neck. R1's Fall Risk assessment dated [DATE] shows R1 is a High Risk for Falling, her gait is weak, and she overestimates or forgets her limits. R1's current care plan shows she has self-care performance deficit related to dementia .she requires partial/moderate assistance with transfers, toileting and bed mobility. R1 is non-complaint to ask for assistance for help to her ADLs (activities of daily living) related to her dementia and poor safety awareness. R1's care plan shows she is a HIGH fall risk related to dementia .prefers to do things herself then requesting for staff assistance, her interventions include encourage her to use her call light for assistance, items within reach and remind R1 to request staff for assistance with toileting and to use her call light to alert staff (same intervention listed twice). R1's current care plan shows R1 may need to use bilateral half side rails to enhance functional independence and promote skin integrity with interventions include side rails as assistive devices to help to turn and reposition for transfers and demonstrate her to take full advantage of the side rails for positioning, turning, and transfers. May need on-going education on the use of the side rails. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility's Proper Use of Bed Rails policy dated 9/2024 states, It is the policy of this facility to utilize a person-centered approach when determining the use of bed rails. Appropriate alternatives are attempted prior to installing or using bed rails. If bed rails are used, the facility ensure the correct installation, use and maintenance of the rails .the resident assessment should assess the resident's risks of entrapment between the mattress and bed rail or in the bed rail itself Informed Consent form the resident or resident representative must be obtained after appropriate alternatives have been attempted prior to installation and use of bed rails the information that the facility should provide to the resident, or resident representative includes but is not limited .the residents benefits from the use of bed rails .the residents risks form the use of bed rails upon receiving informed consent, the facility will obtain a physician's order for he use of the specified bed rail and medical diagnosis, condition, symptom or functional reason for the use of the bed rails . Installation and Maintenance of Bed Rails the facility will assure the correct installation and maintenance of bed rails prior to use. This includes ensuring the bed frame, bed rail and mattress do not leave a gap wide enough to entrap a residents head or body, regardless of mattress width, length or depth the facility will follow manufactures recommendations/instructions regarding disabling or tying rails down The Fall Prevention Program Policy revised 2024 states, Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls High Risk Protocols the resident will be placed on the facility's fall prevention program .provide additional interventions that address unique risk factors measured by the risk assess mention tool .provide additional interventions as directed by the residents assessment, including but not limited to: assistive devices, increased frequency of rounds, sitter if needed, medication regime review, low bed, alternate call system access, scheduled ambulation or toileting assistance, family/caregiver or resident education, therapy services referral .interventions will be monitored for effectiveness. The plan of care will be revised as needed.