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	05/20/2025

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 39537 Based on observation, interview, and record review the facility failed to maintain a written grievance and follow their policy for 1 of 3 residents (R2) reviewed for grievances in the sample of 9. The findings include: On 5/16/25 at 11:31 AM, V20 (R2's daughter) followed the surveyor down the hallway and stated, I filed the complaint. I was upset that my mom's legs looked like that and I filed a grievance on Friday (5/9/25). I filled out the facility's form and turned it in to [V16 (Receptionist)]. I didn't receive any follow-up from [V1 (Administrator)]. I just wanted to make sure the grievance wasn't lost. This wouldn't be the first time they lost a grievance I filed. The ADON (V3) was very helpful that day and provided care to my Mom. I ended up following up on the grievance with Social Services on the following Monday (5/12) or Tuesday (5/13). I can't remember the exact date. The ADON called me with an update on my Mom's skin, but she was very wishy washy. I was never notified what happened to that CNA (Certified Nursing Assistant) and I've seen her around the facility. It would be nice if the Administrator would follow-up with me regarding my grievance. I sent a picture of the original grievance I filed with my complaint. V20's handwritten Concern (Grievance) Form completed on 5/9/25 was on facility letter head. V20 provided a picture of the form when she filed the complaint. It showed that when V20 arrived to visit R2, R2 expressed that she was in pain. This form showed V20 noticed R2's chair was locked and R2's legs were digging into the edge of the table. This document showed after moving R2 back from the table she noticed wounds on R2's shins. On 5/15/25 at 9:05 AM, the surveyor requested the last three months of grievances/concern forms from V1 (Administrator). V20's handwritten Concern form was not included in the forms provided by the facility. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/16/25 at 10:32 AM, the surveyor asked V2 (Director of Nursing - DON) if there were any outstanding Concern Forms because there were no forms after 5/8/25. At 10:43 AM, V2 returned and said the surveyor should have all the concern/grievance forms. The surveyor said there may be a missing grievance form and V2 replied, Uh-oh, I will check. At 10:55 AM, V2 said she spoke with V1 (Administrator) and she said all the Grievances were provided. The surveyor informed V2 there should be a concern form dated 5/9/25 completed by V20 (R2's daughter). V2 stated, I don't know about that. V2 looked down at her phone and replied, Sorry I'm trying to read texts as they come in. It looks like on 5/12/24 R1's daughter was alleging she filed a Grievance Form and gave it the receptionist, but no one can find it. I can create a form from the text message regarding her concern. The surveyor asked V2 when the incident with R2 happened and she replied, I'm not sure. I'd have to check with [V3 - Assistant Director of Nursing (ADON). She was handling this situation. I can have [V3] complete a Grievance Form. V2 read from her phone again, It looks like the daughter was upset about care provided by a CNA and said she was going to call the state. I'm not sure what happened to the Grievance Form. V2 said if V20 turned in a Grievance form then the facility should have it. On 5/16/25 at 1:51 PM,V16, Receptionist, said she works full-time. V16 said she received a Grievance From from V20 on 5/9/25 and she placed it in V2's (DON) box. The surveyor asked where the box was. V16 walked the surveyor into a small office area beside the front desk and pointed to the mail slot labeled DON. V16 said she's not sure what happened to V20's Grievance Form after that. On 5/20/25 at 2:18 PM, V19 (Social Services Director - SSD) said when anyone presents a grievance it is relayed to the appropriate department. V19 said if the concern is clinical then the DON or ADON would be notified. V19 said V1 (Administrator) should be aware of all grievances, but the follow-up may will be assigned to the appropriate department. V19 said after the Grievance is addressed, then the form is returned to V1 or myself. V19 said she did speak to V20 (R2's daughter) on Monday (5/12/25) and she had mentioned that a CNA had pushed R2's wheelchair into the table, R2's legs were bumped, she had concerns with the CNA, and didn't want her assigned to R2. V19 said she notified the DON, ADON, and Administrator. V19 said V20 said she filed a Grievance Form the week prior, but V19 didn't receive it. V19 said she checked with the receptionist and she said she put the Grievance Form in the DON's box. V19 stated, That's why I was unaware until Monday. The forms shouldn't get lost. The purpose is to address any concerns of the family or the resident. It is a way for the family to relay what they are experiencing and have proper follow-up. The facility's Resident and Family Grievances Policy dated 9/1/24 showed, It is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal . Policy Explanation and Compliance Guidelines: 1. The Administrator is responsible for overseeing the grievance process; receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility; maintaining confidentiality of all information associated with grievances; issuing written grievance decisions to the resident; and coordinating with state and federal agencies when necessary in light of specific allegations . 7. Procedure: .b. The staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form, or assist the resident or family member to complete the form . c. The facility will take steps to resolve the grievance, and record information about the grievance, and those actions, on the grievance form .

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F 0689 Level of Harm - Minimal harm or potential for 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** 39537 Based on observation, interview, and record review the facility failed to safely position a dependent resident in a manner to prevent minor injury for 1 of 3 residents (R2) reviewed for safety in the sample of 9. The findings include: On 5/15/25 at 11:27 AM, R2 was reclined at approximately 45-60 degrees in the reclining wheelchair. R2's knees are contracted, pulling here heels up towards her buttocks. This position of the reclined wheelchair made her knees higher than the level of the dining room tables. R2 had bilateral heel protectors on and a donut pillow between her knees. V11 (CNA) parked R2 diagonally next to the table. R2's kneecaps and top of her shin were above the level of the table and her mid shin area was even with the table edge. (This positioning could easily have caused skin breakdown if pushed up to the table in this position.) The table was a square pedestal table. R2 smiled and was able to provide her name, but was unable to provide any details related to her legs. On 5/16/25 at 9:29 AM, V20 (R2's daughter) said she went to visit R2 on 5/9/25 during the noon meal. V20 said R2 has been disabled for a long time and had poor memory. V20 said R2 rarely complains about anything, but that day she was complaining that her shins hurt. V20 said R2 was sitting at a table in the community dining room, the brakes to her chair were locked, and R2's shins were in pressed up against the edge of the table top. V20 said R2's legs are contracted up and her chair reclines so her legs don't fit under the table. V20 said normally the facility staff park R2 parallel to the table, but that day R2 was facing the table with the edge of the table digging into her shins. V20 said she released the breaks from R2's chair and pulled her chair away from the table. V20 said she pulled R2's pant legs up and there were deep indents on both her shins. V20 said her pants were stuck in one of the indents. V20 said V15 (CNA) was sitting in the dining room and she asked her if she placed R2 at there and V15 replied, Yes. V20 said she told V15 that R2's shins were against the table and she had sores. V20 said V15 didn't really react. V20 said she went to V3 (Assistant Director of Nursing) and asked her to come look at R2's situation. V20 said she didn't believe V15 positioned R2 maliciously, but felt it was negligent. V20 said V15 neglected to see that R2 was pushed up so tight to the table that he shins were squished. V20 stated, I have a hard time believing my Mom didn't complain when she put her there. I filed a grievance that day. On 5/16/25 at 11:25 AM, V9 (LPN/Wound Care Nurse) pulled R2's pant legs up to exposed a foam, bordered dressing on both upper shins. V9 carefully peeled back the dressing to expose a small, pea-sized reddened area on R2' right and left upper shins. Neither area was opened, but were in a linear fashion (similar to the edge of a table). V9 stated, They are almost completely healed, but we are keeping them covered for her protection. V9 said she would considered this wounds a traumatic wound or abrasion, but not a pressure wound. R2's Facesheet dated 5/16/25 showed diagnoses to include, but not limited to: cerebral atherosclerosis, peripheral vascular disease, Multiple Sclerosis (MS), abnormal posture, dementia, diabetes, and dysphagia. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's facility assessment dated [DATE] showed she has severe cognitive impairment and was dependent on staff for all ADLs. R2's Progress Note dated 5/9/25 at 3:55 PM by V14 (Licensed Practical Nurse - LPN) showed, Resident noted with redness on the left shin and dry scab from her legs getting up against the table, Tylenol 660 mg given for pain and was effective .: R2's Skin/Wound Note dated 5/9/25 at 1:27 PM showed, The writer was notified that the patient is with a wound on her lower extremity. Assessment done. Noted on bilateral shin area measuring 1.5 x 1 cm with induration and liner blanchable redness in the center, no open skin. Peri-wound normal. Patient did not complain of pain at the site. Could not tell the writer how she got those bumps. Area cleansed and covered for protection. NOD (nurse on duty) notified. R2's Care Plan did not address the skin concerns as a result of 5/9/25's incident. On 5/16/25 at 12:36 PM V15 (CNA) said she worked R2's assignment on 5/9/25 and that was only her second time providing care for R2. V15 said she and the nurse positioned R2 at the table. V15 said R2 was pushed up to the table (at a 90 degree angle, not parallel to the table.) V15 said R2's legs were not touching the table when she left her. V15 said R2 does sit at the table with two other residents and it is possible that one of them moved the table into R2's shins. V15 said when V20 (R2's daughter) came to visit, during the noon meal, she said R2's legs were touching the table and R2 was complaining of pain. V15 said the nurse went to check her legs and she did see there were little indentations to R2's shins, like something had pushed up against her leg. V15 said V20 said when she arrived R2's legs were pushed up against the table and she asked if I was here CNA. V15 said I told her that I was but her legs weren't in contact with the table when I locked the breaks. V15 said V20 (R1's daughter) got the ADON and DON. V15 said they talked to her about it, but she would never purposely hurt anyone. V15 stated, All I can think is when one of the other residents sat down, they pushed the table into R2. I didn't want to escalate the situation, so I had a different CNA take over R2's care. On 5/16/25 at 11:25 AM, V2 (ADON) said she was working 5/9/25. V2 said around lunch time, V20 (R2's daughter) was teary and said something was going on with R2's shins. V2 said V20 reported the CNA bumped R2 and R2 had marks on her shins. V3 said she went to assess R2's skin and she did see redness to both her shins. V3 said R2 grimaced when she touched her shins. V3 said she told the nurse give R2 pain medication, notified the Nurse Practitioner, and called hospice. V3 said she was in the dining room [ROOM NUMBER] minutes prior to this and R2 was smiling and happy. V3 stated, I don't know if the table got pushed into her shins when the other residents sat down. V3 said R2 should be positioned parallel to the table, so the table edge won't push up against her shins. V3 said R2's wounds were linear across both her shins. It looked like R2 came in contact with the table, but I don't know how. V3 said being up against a hard surface could lead to skin breakdown. V3 said R2 doesn't normally complain of pain, but she did that day. The facility's Skin Integrity-Skin Tears Policy dated 9/1/24 showed, It is the policy of this facility to provide proper treatment and care to maintain skin integrity. This policy pertains to the prevention and management of skin tears . Policy Explanation and Compliance Guidelines: .3. Interventions for Prevention and to Promote Healing. a. Interventions will be based on specific factors identified in the skin and comprehensive assessments. Categories of interventions to consider include, but are not limited to: i. Interventions to provide a safe environment