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	05/27/2025

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 40798 Based on observation, interview, and record review, the facility failed to ensure dressing changes and/or intravenous (IV) tubing changes were completed to decrease the potential for infection for 2 of 2 residents (R1 and R2) in the sample of 2 with central lines. The findings include: On 5/27/25 at 9:38 AM, R1's PICC (peripherally inserted central catheter) insertion site to his right upper arm was dressed, but it was not labeled with a date or time. R1 had antibiotics infusing and the tubing was not labeled with a date or time. R1 said the staff do not change his PICC dressing every week as is required. On 5/27/25 at 10:25 AM, R2 had antibiotics infusing via his PICC line. The tubing was not labeled with the date or time. R2 said staff had not changed his PICC dressing for almost two weeks and the IV medication tubing is supposed to be changed every 24 hours, but it is four days old. On 5/27/25 at 10:34 AM, V6, RN, said they can use the same IV tubing for 72 hours, but he changes the tubing every day, so he does not date/time the tubing. V6 said PICC dressing changes are every week. V6 said the PICC dressing changes are documented on the EMAR/ETAR (electronic medication administration record/electronic treatment administration record) when they are done. V6 said if it is not signed off, then it has not been done. On 5/27/25 at 11:49 AM, V5, Registered Nurse (RN), said the PICC line dressing is supposed to be changed by an RN weekly and the dressing is dated, timed, and initialed and documented on the TAR. V5 said the IV tubing needs to be changed every 24 hours for each medication being administered. On 5/27/25 at 12:25 PM, V4, Licensed Practical Nurse (LPN) said the PICC dressing is supposed to be changed every seven days and the IV tubing needs to be changed every three days. V4 said the IV tubing is supposed to be dated with the date it was changed. On 5/27/25 at 1:07 PM, V2, Director of Nursing (DON), said she does not know how long a set of IV tubing can be used before needing to be changed, but the tubing should be dated when it is changed. V2 said she does not know if PICC line dressings should be dated. V2 said PICC dressings are changed once a week and documented on the TAR. V2 said if a medication or treatment is not documented, it has not been done. (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
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Serenity Estates of Lincolnshire	150 Jamestown Lane Lincolnshire, IL 60069

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/27/25 at 2:43 PM, V3, Assistant DON/Infection Prevention nurse, said IV tubing for intermittent medications should be changed every 48 hours to prevent the contamination of the IVs when they are not being used. R1's TAR for 5/1/25 through 5/31/25 shows his IV catheter dressing was not changed as ordered on 5/19/25 or 5/26/25. R1's Order Summary Report dated 5/27/25 shows an order dated 5/19/25 to change R1's (PICC) IV catheter dressing every Monday. The facility's Intravenous Therapy Policy (implemented 9/1/24) shows primary intermittent infusion sets (tubing) are changed every 24 hours or sooner if contamination is suspected. All IV tubing is to be labeled with date, time and initials. The facility's PICC/Midline/CVAD Dressing Change Policy (implemented 9/1/24) shows it is the policy of the facility to change peripherally inserted central catheter (PICC), midline or central venous access device (CVAD) dressing weekly or if soiled, in a manner to decrease potential for infection and/or cross contamination. The procedure is to be documented.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 40798 Based on interview and record review, the facility failed to administer intravenous (IV) antibiotics as ordered by the physician for 2 of 2 residents reviewed for intravenous therapy in the sample of 2. The findings include: On 5/27/25 at 10:25 AM, R2 said he is supposed to get IV (intravenous) antibiotics twice a day. R2 said he missed an entire day of antibiotics, both doses, because the medication did not get ordered. On 5/27/25 at 9:35 AM, V5, Registered Nurse (RN), said R1 has IV antibiotics ordered every 12 hours. On 5/27/25 at 10:34 AM, V6, RN, said R2 gets IV antibiotics every 12 hours. V6 said once the medication administration is started, he charts it on the EMAR (electronic medication administration record). V6 said if a medication is not signed off, that means it has not been given. On 5/27/25 at 12:25 PM, V4, LPN (licensed practical nurse), said R2 was on IV antibiotics every 12 hours at 9:00 AM and 9:00 PM. V4 said she checked for R2's IV antibiotics (Vancomycin) and there was no more. V4 said she called V2, DON (director of nursing), V2, and they looked together. They could not find the dose for the next shift on 5/10/25, so she called the pharmacy and was told the medication would arrive for the next shift. V4 said she knows R2 did not get his Vancomycin on (Tuesday) 5/13/24. V4 said she put in a progress note and informed R2 that the medication was not available. V4 said she put a code 9 on R2's MAR which means see progress notes. V4 said a code 11 means the medication is not available. V4 said she works a double shift (day shift and evening shift) on Tuesdays. On 5/27/25 at 11:49 AM, V5, RN said R1's Vancomycin was not available for the evening dose on 5/6/25. V5 said she went home that night at 11:30 PM and it had not been delivered. On 5/27/25 at 1:07 PM, V2 said if an ordered medication is not available, the nurse can check the convenience box and they can call the pharmacy. V2 said she and V4 went together and looked for R2's medication and it was not there. V2 said V4 was going to call the pharmacy, but she does not know what the outcome was. V2 said it is important for residents on IV antibiotics to get their scheduled doses because they are ordered by the doctor. V2 said if a medication is not documented as being given, then it was not done. On 5/27/25 at 2:47 PM, V2 said if a medication cannot be obtained, the nurse needs to notify the doctor and follow any further instructions. On 5/27/25 at 2:43 PM, V3, Assistant DON/Infection Prevention nurse, said if a medication is not available, the nurse should be checking the convenience box and if it's not there they should be calling the pharmacy to see if they can deliver it sooner, and then inform the nurse practitioner, doctor, and/or infectious diseases. R1's MAR for 5/1/25 to 5/31/25 shows R1's Vancomycin was not available (code 11 documented) on 5/6/25 for his 9:00 PM dose. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's MAR for 5/1/25 to 5/31/25 shows R2's Vancomycin was not administered on 5/10/25 at 9:00 PM or on 5/13/25 at 9:00 AM nor 9:00 PM. R2's Progress Notes dated 5/13/25 at 2:28 PM show the pharmacy was contacted regarding R2's antibiotics and was told they would arrive at the next scheduled delivery later that day. R2 was informed and the convenience medication box did not have any of the ordered antibiotics. R2's Progress Notes dated 5/13/25 at 10:46 PM show R2's Vancomycin still had not arrived at that time. The facility's Medication Administration Policy (implemented 9/1/24) shows medications are administered as ordered by the physician following the six right of medication administration: right resident, right drug, right dosage, right route, right time, and right documentation. The MAR is reviewed to identify medication to be administered. The MAR is signed after the medication is administered.