| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146028 | A. Building<br>B. Wing | 01/28/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Serenity Estates of Lincolnshire | 150 Jamestown Lane<br>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.

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>Based on observation, interview, and record review the facility failed to notify a resident's family and nurse practitioner after the resident fell. This applies to 1 of 3 residents (R1) reviewed for nursing care in the sample of 5. The findings include:R1's admission Record (Face Sheet) showed an original admission date of 5/13/25 with diagnoses to include but not limited to dementia, pubic fracture (onset date 6/27/25), osteoarthritis (joint cartilage breakdown), right shoulder bone density disorder, and spinal stenosis. On 1/22/26 at 12:30 PM, R1 was in bed, asleep, and did not awaken to her name. R1 had faded bruising to the left side of her face; the remainder of her body was covered in a blanket. R1's 1/15/26 Nurse's Note from 7:17 PM showed, Resident with fall from bed at 1610 (4:10 PM) while attempted self-transfer and fell to floor on her left side and bumped the small dresser. Small bruise on left side of forehead. (note authored by V7 Registered Nurse) On 1/21/26 at 1:57 PM, V7 Registered Nurse stated she did not notify R1's family of the fall on 1/15/26 until the next day. V7 stated she should have notified the family of the fall the day it happened. V7 said R1 must have hit her head due to a mark and small bruise that was forming on the left side of her head. R1's Nurses Note from 1/19/26 at 6:10 AM, During routine rounds at around 12:30 a.m., the resident was observed lying supine on the floor in her room. She was wearing non-skid socks and was gesturing to staff to get her up. (Less than 24 hours after this fall R1 was diagnosed with a fractured left hip and left elbow. Note authored by V16 Licensed Practical Nurse.) On 1/23/26 at 8:55 AM, V16 stated she did not notify the family or the nurse practitioner after R1's fall on 1/16/26. On 1/22/26 at 2:01 PM, V6 R1's Daughter/Power of Attorney stated she was not notified of R1's fall on 1/15/26 until 1/16/26 at noon. V6 said she was not notified of R1's fall on 1/19/26 until 1/21/26 when V2 Director of Nursing told her. V6 said she expects the facility to call her right away. V6 said, I need to know what is going on. On 1/23/26 at 10:56 AM, V2 Director of Nursing stated staff are expected to notify the family and provider after a resident falls. V2 said notification is important so family and providers are notified of changes and can make informed decisions. On 1/23/26 at 10:30 AM, V17 Nurse Practitioner stated she did not round on R1 on 1/19/26. V17 said if she had been notified of a fall on 1/19/26 she would have seen the resident in the morning while she was at the facility. V17 said notification is important so she is aware of what is going on with her residents and so she can make fully informed decisions. The facility's Fall Prevention Program showed (Reviewed 9/1/24) when any resident experiences a fall, the facility will: assess the resident, complete a post-fall assessment, complete an incident report, notify physician, notify family, and document all assessments and actions. |

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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide necessary care, services, and translation services after a resident experienced a fall and subsequent hip and arm fractures. This failure resulted in R1 experiencing pain and a delay in treatment. This applies to 1 of 3 residents (R1) reviewed for nursing care in the sample of 5. The findings include: R1's admission Record (Face Sheet) showed an original admission date of 5/13/25 with diagnoses to include but not limited to dementia, pubic fracture (onset date 6/27/25), osteoarthritis (joint cartilage breakdown), right shoulder bone density disorder, and spinal stenosis. R1's 11/19/25 Quarterly Minimum Data Set (MDS) showed Mandarin was her preferred language and she would like an interpreter to communicate with a doctor or health care staff. The MDS showed she was not able to complete a Brief Interview for Mental Status (BIMS) test and she had both short and long-term memory problems. The MDS showed she had no range of motion limitations to her upper or lower body extremities, and she used a wheelchair for mobility. The Functional Abilities section of R1's MDS showed she required substantial/maximal assistance (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.) for eating, oral hygiene, toileting hygiene, dressing, putting on footwear, sit to stand, chair/bed transfers, and walking 10 feet. On 1/22/26 at 12:30 PM, R1 was in bed, asleep, and did not awaken to her name. R1 had bruising to the left side of her face; the remainder of her body was covered in a blanket. On 1/21/26 at 9:35 AM, V4 Lieutenant Firefighter/Paramedic with facility's local fire department stated he responded to a 911 call on Monday 1/20/26 at 1:30 AM for a fall. V4 stated when he got there R1 was asleep in bed and not on the floor. V4 stated The nurse said she fell on the 15th (1/15/26, Thursday) and we just got X-rays, and she has a broken hip. I asked, 'Why didn't you call on 15th and she said I don't know, I wasn't here when she fell. We went to take blood pressure on the left arm, and she immediately winced in pain. Nurse walks up and says she has a broken left hip and left forearm; that would have been nice to know beforehand. V4 said, R1 only spoke Chinese. V4 said, We tried Google translate and we were not having good luck. We asked the facility how they communicate, and they said they speak English to her and they said we just know what she wants based on her grunts and groans. They said they don't have a translator. V4 said, The nurse read us the fall report from the 15th, and they didn't call EMS at that time. two RNs (registered nurses) were with us. V4 reiterated, They (two nurses) both said they did not have translation services. They said we speak English to her and then we just know what she wants or needs based on her moans and groans. V4 was asked about any abnormal findings with R1, he replied, The first thing we noticed was bruising to left side of her face that looked old. Then once we took blood pressure of her left arm there was guarding (person protecting a body part by moving the body part when touched), so we moved her to a back board for stabilization. They (other paramedics) did look at the left leg, but I wasn't the one that assessed it, I was in charge . They (nursing staff) read me the assessment from the 15th but they said everything was normal on the 15th, which got me wondering, with the displaced fracture in the left arm and the broken hip, how did they move her and toilet her with broken bones? V4 stated, V5 Firefighter/Paramedic with the facility's local Fire Department was the paramedic who was most involved in R1's assessment. V4 stated he did not know the names of the nursing staff. On 1/21/26 at 11:03 AM, V5 stated When we got there, they informed us she had fallen 5 days ago, they just got Xrays, and they only told us about the hip fracture. She winced in pain when we tried to take her blood pressure on the left arm. V5 stated they tried a translation app on their phone but they were unsuccessful. V5 stated, when the paramedics placed her on the back board she winced in pain with movement.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | V5 said, when he got to the hospital with R1 the Emergency Department nurse removed her sweater and her left elbow was obviously swollen. V5 stated he spoke to nursing staff at the facility and they read the notes from the fall on the 15th and the notes said she was in no obvious pain. R1's Ambulance Run Report (Authored by V5) showed they were dispatched at 1:18 AM on 1/20/26 and arrived to the R1 at 1:31 AM. The report showed, .hip and left forearm fracture from a fall 5 days prior. Staff state they received report that the pt (patient) began moaning in pain in the morning and is why she was sent out for X-rays. Staff stated that the pt was acting to her norm and only speaks Chinese.Crew noted pt winced when examining her left forearm but could not feel any obvious deformity. R1's Nurses Notes from 1/15/26 (Thursday) at 7:17 PM, showed Resident with fall from bed at 1610 (4:10 PM) while attempted self-transfer and fell to floor on her left side and bumped the small dresser. Small bruise on left side of forehead, anxious, moving all extremities, and attempting to get up off the floor. (Note authored by V7 Registered Nurse, RN) On 1/21/26 at 1:57 PM, V7 RN stated (regarding R1's fall on 1/15/26) R1 rolled out of bed and hit her head on the bedside table. V7 said, She was very antsy and kept wanting to get up but nothing was broken. I saw her a couple of days later and she was walking with the wheelchair out in front of her.it must have been Saturday that I saw her walking. V7 stated she notified the Nurse Practitioner of the fall. On 1/21/26 at 12:11 PM, V6 R1's Daughter and Power of Attorney stated, I went and saw her over the weekend after the fall and she was walking, but she has to be supervised. Yeah, it was this last weekend. I was there from 11:00 AM to 4:00 PM on Saturday and she was walking and doing fine. She did walk a little bit, maybe 10 yards, then had to rest. Then Sunday my brother went there and tried to get her to move, and my brother said she walked a lot, and she was really strong. She was not having pain. V6 said R1 was walking and using both arms to stabilize herself without pain or discomfort. V6 said she did not notice any pain or guarding with R1's left arm. V6 said, Monday night I got a call.they said they were going to send her out for a fracture. I don't know why they did the Xray. She was fine over the weekend, I should try to figure that out. Monday night, when they called about sending her out, the nurse told me she fell several days ago. They always call me when she falls; no problems there. R1's EHR showed V13 RN entered an order for an X-Ray of the left forearm and left hip due to pain. The X-Ray order was entered on 1/19/26. The facility's schedule showed V13 RN was R1's day nurse (7:00 AM to 3:00 PM) on Friday, Saturday, Sunday, and Monday (1/16/26 through 1/19/26). On 1/22/26 at 11:57 AM, V13 stated R1 was fine over the weekend, and she had no pain. V13 stated R1 did not have a fall during her shift on 1/19/26 (Monday). V13 said, .the off-going night nurse (V16 Licensed Practical Nurse) told me that she (R1) was in pain. I'm pretty sure it was Monday, and she asked if I could get an order from the NP (Nurse Practitioner). She asked me to get an order for an Xray and for pain medication. When I asked the NP, I got a stat Xray order. It was [V16] and she said I should get an order for pain meds (medications) and an Xray. [V16] did not say that anything happened Sunday night, she didn't say anything about a fall. She said when she went in to check on her in the morning, she (R1) was having pain in her left arm and she (R1) was pointing to her hip. When I worked with her on Sunday, she (R1) was not having any pain. I did work a double on Sunday. If I knew about a fall, I would have told the NP about it when I got the order for the Xray. [R1], she does not have pain. She does not speak English. When I tried to touch her left arm on Monday, she retracted the left arm and she was not like that on Sunday. [R4, R1's roommate] did not say anything about what happened to [R1]. V13 said R4 is not known to make up allegations. On 1/22/26 at 10:08 AM, V10 Certified Nursing Assistant (CNA) stated she was R1's CNA when she fell on 1/15/26. V10 said after R1's fall she did not have any pain, and she was at her baseline. V10 said R1 was not her resident on Friday 1/16/26; however, she did assist<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | R1 to the bathroom and R1 had no pain. V10 said, I did not have her on Monday (1/19/26), [V11 CNA] had her on Monday. It was mealtime and I asked [V11] where she was and he said she was in bed and I asked why and he said I don't know why. He told me her (R1) roommate said she had a fall on Sunday night. On 1/22/26 at 10:57 AM, V11 CNA stated .She (R1) did not get out of bed on Monday. She was sleepy that day. She usually eats in the dining room but that morning she ate in her room. When I would clean her up, she kept saying a word over and over again. The word was Iyo, Iyo, Iyo, over and over and over again. I don't know what it means. I did not get a report that she had a fall the night before. [R4] said she had a fall but, I think she was referring to a fall from the week before. I was emptying [R4's] catheter on Monday morning and [R4] asked how her roommate was doing because she had a fall but I don't remember when she said [R1] fell. I don't know if they have any translator services or not. Translator services would be beneficial then I would know what they are saying and what they need like the word that [R1] was saying. She just kept saying Iyo, Iyo, Iyo over and over again when I changed her brief on Monday. She did not get out of bed on Monday. I did not notice any swelling on her left arm. On 1/22/26 at 11:20 PM, V6 R1's Daughter stated Iyo it means ouch, like pain. On 1/22/26 at 10:25 AM, R4 (R1's roommate) said I think she (R1) had a fall Sunday night. She was over here, she was on my side of the room, touching my tv. The daughter said to me she doesn't speak English. I'm pretty sure it was Sunday, but it wasn't the 15th, I know it wasn't the 15th, because people were asking me about it. [V2 Director of Nursing, DON] came and talked to me about it. I heard her (R1) fall, and I knew it was a bad one. I knew it was bad because it was loud. She crawled over to my side, it was the middle of the night, so I pushed the button, and she had wedged herself by the door so they couldn't push the door open. They finally came in and pulled my curtain. The nurse brought her out to the nurses' station, and I think they called a gentleman to help or a male nurse. They took her out in the chair and then later put her back in the bed. I think it was just the CNA that put her back in bed and I could tell she was in pain. I knew she was in pain because she was moaning and yelling. I'm certain the fall was on the weekend.Then they did Xrays on Monday, so yes, the fall happened Sunday night because they did the Xrays the next day after the fall, that I do remember. The staff don't use any translator services. Sometimes I will try to communicate with her through google translate. I asked the daughter what some of the words mean that she says all the time and she told me they mean pain and bathroom. On 1/22/26 at 12:23 PM, R4 said Normally when they get her (R1) up she doesn't make any noise but on Monday she was complaining a lot. I knew she was in pain on Monday when they were moving her. Yes, she kept saying Iyo, Iyo, Iyo. Does that mean ow? R4's 12/11/25 Quarterly MDS showed she was cognitively intact with a BIMS score of 15 out of 15. On 1/21/26 at 10:36 AM, following R1's fall note on 1/15/26 at 7:17 PM, R1's Electronic Health Record (EHR) showed no other fall documentation in either the assessment section or the progress notes. R1's NP Note with a 1/15/26 Date of Service (Authored by V17 NP) showed, Patient had a fall from bed on 1/15/2026 while attempting self-transfer, resulting in a small bruise to the left forehead; no change in mental status, pain, or ADL (Activities of Daily Living) function reported post-event. (No similar NP assessment was completed on 1/19/26 per R1's EHR. This note was a PDF document and was electronically signed on 1/19/26 at 11:53 AM.) R1's 1/20/26 Orthopedic Physician Consult Note showed, [R1] is a [AGE] year old female presenting with a complaint of LEFT hip and LEFT elbow pain after a fall sustained apparently 5 days ago.Patient resides at [the facility] and staff reported patient started moaning last night and noticed bruising to the elbow and forehead so they performed Xrays at the facility which reported a left hip and left elbow fracture. The note showed she had a fractured left hip and a displaced (the bone has shifted at the fracture point) left elbow fracture. The note showed the<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | family elected not to pursue surgical interventions and they are now contemplating palliative care services. (No mention of a fall on 1/19/26.) On 1/23/26 at 9:56 AM, V16 Licensed Practical Nurse (LPN) stated V12 LPN was originally scheduled to be R1's nurse for the third shift beginning on 1/18/26; however, herself and V16 switched assignments. (The facility's staff scheduled showed V12 was assigned R1 for that shift.) V16 said at approximately 12:30 AM on Monday 1/19/26, she was doing rounds and found R1 on the floor. V16 said the call light turned on as she was going into the room. V16 said, nothing seemed abnormal regarding her assessment of R1. V16 said, I did look at her entire body, she was in a brief, nothing was abnormal or out of range. V16 said R1 did not have pain during her shift. V16 said, she gave acetaminophen (over the counter pain medication) just in case. V16 said After a fall, in case there is any achiness, I just give them [acetaminophen]. V16 said after R1 fell she was brought out to the dining room adjacent to the nurses' station for approximately 3 hours. V16 said she was not in the room when R1 was put back to bed and she was not notified of R1 having pain when she was put back to bed. V16 said, I would want to be notified of the resident being put back to bed and if she was having pain. That creates a more serious issue; I may need to do further interventions. If I had been aware, I would have called the NP at that time to get orders. We did let the NP know because she gave the Okay for the testing. The oncoming nurse let her know. V16 said she documented the fall in R1's progress notes. V16 said the NP was not notified; however, V16 stated she did notify the oncoming nurse (V13). V16 was asked, why she requested an Xray, if per her assessment, nothing seemed abnormal or out of range? V16 stated, We do an Xray just in case. (During V13's interview, V13 denied being notified of a R1 falling; however, she stated she was notified, by V16, of R1's pain during V16's shift.) R1's progress notes showed a note was entered into R1's chart by V16 with an effective date of 1/19/26 at 6:10 AM; however, the note was created on 1/21/26 at 2:29 PM (2.5 days after the fall occurred and after the initiation of the survey.) The note showed, During routine rounds at 12:30 a.m., the resident was observed lying supine on the floor in her room. She was wearing non-skid socks and was gesturing to staff to get her up. She was not able to state what she was trying to do and was speaking Chinese. She did not have any complaints of pain or discomfort were observed. She did not have any bumps, redness, or new areas of skin discoloration to her head. She was assisted from the floor to the w/c (wheelchair) with the assistance of two staff members. Vital signs were assessed and stable. [Acetaminophen] was offered and given. This writer used a translator app, and stated she was hungry. We provided a peanut butter sandwich, a pudding, and a mighty shake, which was consumed. The resident was placed with the CNA for closer supervision. At around 4:00 a.m. the resident was sleeping in the w/c, so she was assisted to bed. The resident was quiet and sleeping the remainder of the shift. R1's Medication Administration Record showed an order for two 325 milligram acetaminophen tablets to be given for as needed every six hours for Mild to Moderate pain. V16 documented administration of acetaminophen at 12:30 AM on 1/19/26 for a Pain Level of zero. V15 CNA assigned to R1 third shift the evening beginning on Sunday 1/18/26 was called on 1/22/26 at 1:18 PM and 1/23/26 at 8:48 AM. V15 returned call on 1/23/26 after work hours. A third attempt was made on 1/27/26 at 1:20 PM. On 1/22/26 at 2:01 PM, V6 R1's Daughter stated she was notified of R1's fall by V2 Director of Nursing on 1/21/26. On 1/23/26 at 10:30 PM, V17 Nurse Practitioner stated, .on Monday the nurse said she was having pain, but nothing was abnormal, then they got the Xrays back way early in the morning and sent her (R1) out. I remember the nurse saying she had a fall, she didn't say the date of the fall, so I'm not actually sure of the specifics of the fall or when it happened, she could have been talking about the fall on the 15th.I did not see her on Monday (1/19/26), I think I was already gone, so probably sometime after noon. V17 stated the date of service is the<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | date she saw R1. V17 said when she electronically signed R1's note it must have also entered a progress note. (R1's EHR showed a progress note authored by V17 on 1/19/26 at 11:53 AM. The note was identical to V17's PDF note from 1/15/26 which was electronically signed on 1/19/26 at 11:53 AM. This made it appear as if V17 had assessed R1 on 1/19/26.) V17 said, If I had been told that she was having pain and she had a fall I would have seen her while I was here and maybe done something different than an Xray. Those fractures can be painful with movement, especially the hip fracture. I would think the injury happened on the 19th. I do know [R4]. She is alert and oriented. She has MS (multiple sclerosis) and she is a good historian. If I had reviewed the chart (R1's chart), I would not have seen the fall note if it was not entered until 1/21/26. I was totally reliant on the day nurse (on 1/19/26), the information she had, and what she was telling me. If she (day nurse) didn't know about the fall on the 19th then I would not have known. I need to know all of the information, so I know what to do and what to prescribe, so I really rely on them as to what I need to do. [Acetaminophen] should not be given after a fall 'just in case.' It should be given for pain or fever, that is the indication. We don't order an Xray if the post fall assessment is fine and there is no pain. We don't order an Xray 'just in case.' One 1/21/26 at 11:02 AM, V4 stated, I'd say it does make assessment challenging (lack of translation services). We tried with our own translation services (phone translator) with minimal response. Only thing we have left would be a physical assessment. Being able to communicate with the patient makes things significantly better. On 1/23/26 at 10:56 AM, V2 Director of Nursing stated, following a fall the staff should assess the resident, do vital signs, assess for pain, document in the medical record and do an incident report. V2 said the oncoming shift should be notified as well as the nurse practitioner. V2 stated it is acceptable for nursing staff to give acetaminophen prophylactically (to prevent) for pain after a fall. V2 said shift-to-shift communication is important so the nurses are aware of the condition of their residents. The facility's Effective Communication and Language Assistance Services policy (Reviewed/revised 9/1/25) showed, Purpose: To ensure all residents receive clear, respectful, and understandable communication and have timely access to language assistance services necessary to participate fully in their care. Policy Statement: The facility will provide effective communication to all residents and language assistance services at no cost to residents with limited English proficiency and/or other communication needs, in accordance with federal and state regulations.Language Assistance Services: Oral interpretation, written translation, or other aids provided at no cost to ensure residents can understand and access health care services. The facility's Change in Resident's condition Policy (Reviewed 9/1/24) showed, Document the resident's assessment in the medical record as applicable. (Head-to-toe assessments, vital signs, diagnostic results, laboratory results, behaviors, etc.) The facility's Fall Prevention Program showed (Reviewed 9/1/24) showed when any resident experiences a fall, the facility will: Assess the resident, complete a post-fall assessment, complete an incident report, and document all assessments and actions. |