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	02/11/2026

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

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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 - Immediate jeopardy to resident health or safety 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** Based on interview and record review the facility failed to ensure a resident with cognitive impairment did not elope the facility and failed to ensure all residents were accounted for one of three residents (R1) reviewed for safety/supervision in the sample of seven.The Immediate Jeopardy began on February 4, 2026, at 5:43 AM when R1 was found sitting outside in the cold in her wheelchair by herself, a block away from the facility and was transferred to the local hospital for cold exposure. V1 Administrator was notified of the Immediate Jeopardy on February 9, 2026, at 3:45 PM. The surveyor confirmed by interview and record review that the Immediate Jeopardy was removed on February 10, 2026, at 10:34 AM, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training.Findings include:R1's admission Record shows she was admitted to the facility on [DATE], with diagnoses including left femur fracture, urinary tract infection, unsteadiness on feet, anxiety disorder, malnutrition, dementia, alcohol abuse, pulmonary fibrosis, and altered mental status.R1 Elopement Risk assessment dated [DATE], shows R1 has a high risk of elopement.R1's Minimum Data Set, dated [DATE], shows that R1 is not cognitively intact.On February 5, 2026, at 1:01 PM, V6 Certified Nursing Assistant (CNA) said R1 is able to wheel herself in the wheelchair. V6 said R1 likes to wander the facility.On February 5, 2026, at 2:21 PM, V8 Licensed Practical Nurse (LPN) said R1 wanders the building by self propelling in her wheelchair.The facility's Walkers binder that is left near the receptionist desk and includes pictures and face sheets of residents that wander, was reviewed on February 9, 2025. R1's picture was not included in this binder.R1's Care Plan initiated October 1, 2025, shows R1 demonstrates cognitive impairment and R1 is at risk for falls related to current medication use, poor safety awareness, unsteady gait, decline in functional status, dementia, hip fracture, history of falls, and poor safety awareness.R1's Certified Nursing Assistant task documentation dated January 13, 2026, and January 14, 2026, shows R1 had behaviors of elopement.R1's Chronic Care Management note entered by V11 Nurse Practitioner (NP) dated January 29, 2026, shows R1 has severe impairment of cognitive status.R1's Acute Care Note dated February 1, 2026, entered by V11 NP shows that R1 was disoriented.R1's Incident Note dated February 4, 2026, at 9:07 AM entered by V3 Registered Nurse (RN) shows R1 was seen in bed asleep at 4:00 AM. V3 was notified by the police around 6:00 AM that R1 was taken to the local emergency room. R1 was observed by the police outside of the facility.On February 5, 2026, at 1:21 PM, V9 Police Officer said the previous day (February 4, 2026) a concerned passerby called 911 and reported a person sitting in a wheelchair in the cold. V9 said they originally received the call at 5:42 AM and V9 got there at 5:43 AM. V9 said he was nearby to the area. V9 said when he got there, there was a sweater on the ground near R1. V9 said R1 was disoriented and very cold and smelled like urine. V9 said R1's pants were wet in the groin area presumably with urine due to the strong urine smell. V9 said R1 had a thin sweater on. V9 said he did not know where R1 came from. V9 said R1 was sitting in a (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	wheelchair about a block away from the facility. V9 said R1 had no winter gear on. V9 said R1 told him she was outside all night. V9 said R1 was shivering and had a shaky voice because it was cold outside. V9 said that R1 did not know where she lived nor did R1 say where she was going. V9 said he gave R1 his coat when R1 got into his police car to warm her up. V9 said the fire department came quickly and brought R1 to the hospital to be evaluated. V9 said he went to the facility after the fire department took R1 to the hospital. V9 said he talked to V3 Registered Nurse (RN), V4 RN, and V5 Certified Nursing Assistant (CNA). V9 said V4 RN was his first contact when he got to the facility. V9 said the facility did not know that R1 left the facility. V9 said that an exit door alarm went off about 3:30 AM, but the staff was unable to confirm the cause or origin of the alarm. V9 said that V3 RN reported to him that she turned off an exit door alarm but did not see anything. V9 said he went back by the facility to see if he could figure out what direction R1 took when she left the facility. V9 says he believes R1 left near the employee exit door because the sidewalk was not shoveled. V9 said he saw R1's wheelchair markings in the snow. V9 said the outside temperature was 17 degrees (Fahrenheit/F) because he looked it up when they picked up R1.An observation was made of the sidewalk that R1 potentially took. There were a couple of broken areas of concrete and also unlevel concrete. The sidewalk goes around the facility to the back of it which leads into a parking lot of a shopping plaza.On February 9, 2026, at 9:21 AM, V4 Registered Nurse (RN) said one of the staff members in the facility called her and reported that there was a police officer (V9) at the facility. (On February 4, 2026) V4 said she was the nursing supervisor on that shift. V4 said the police officer got to the facility around 6:00 AM. V4 said the police officer was asking about R1. V4 said she was not aware of the resident, so she looked up the resident's name in the computer and saw that R1 was a resident in the facility. V4 said she called R1's nurse which was V3 RN. V3 came to talk to V9 police officer. V4 said the staff did not know that R1 was gone out of the facility until the police officer came to the facility nor does anyone know what time R1 got out of the facility. V4 said all of the exit doors have alarms on them for when someone exits the facility. V4 said she did not hear any alarms going off. V4 said if a door alarm goes off, then all staff perform a head count on the residents to make sure they are all there. V4 said she was never notified that an alarm went off, nor did she perform a head count on the units she was responsible for.On February 9, 2026, at 9:07 AM, V3 Registered Nurse (RN) said that R1 self propels herself in her wheelchair. V3 said a police officer arrived to the facility around 5:30 AM and said a resident had gotten out of the facility and was taken to the hospital. V3 said she made her last rounds at 4:00 AM, and R1 was asleep in her bed. V3 said no staff knew that R1 had gotten out of the facility. V3 said she did not know what door R1 left out of. V3 said all exit doors are alarmed. V3 said the main exit door alarmed at about 3:00 AM/3:20 AM. V3 said she shut the alarm off, looked outside, and did not see anyone. V3 said it was very cold outside. V3 said all the residents were counted after the alarm went off but she did not report the alarm to the nurse on the other units. V3 said she called the local hospital after she was made aware that R1 had exited the facility. V3 said the hospital told her that R1's body temperature was low. V3 said the typical procedure for when an alarm goes off is to let all the staff know so that a head count can be performed.On February 5, 2026, at 2:02 PM, V5 Certified Nursing Assistant (CNA) said she last checked on her residents around 3:45 AM and R1 was in her bed asleep. R1's door was closed. V5 said they were made aware that a resident left the facility when the police officer (V9) came to the facility. V5 said they do not know how R1 got out of the facility. V5 said she did not recall any exit door alarms going off. V5 said an exit door would alarm if a resident got out. V5 said if an alarm goes off, the nursing supervisor will go to the door. V5 said the facility staff perform a (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	head count of all of the residents. V5 said she was made aware of a door alarm that had sounded about 3:45 AM (conflicting statement) and the staff performed a head count. V5 said all the residents were there. V5 said that R1 is able to get in and out of bed on her own and self propels in her wheelchair. V5 said R1 cannot walk and R1 is disoriented and confused at times.R1's Emergency Medical Service (EMS) Report dated February 4, 2026, shows that EMS arrived on the scene with R1 at 5:55 AM. Patient condition: Complaint: Cold exposure, primary symptoms: Chills. R1 was confused. Assessment Summary: Skin cold. Narrative: Dispatched for a check for wellbeing. Upon arrival, crew made contact with the patient who was awake and alert, talking with cops. The patient informed the crew that she had been outside all night. The patient informed the crew that she had been living outside for a couple of months. Patient informed crew she felt cold. Provider Impression: Primary: Hypothermia-Initial Patient Acuity: Emergent.R1's emergency room Department Notes dated February 4, 2026, at 6:19 AM shows R1 presented to the emergency department for cold exposure. At 9:07 AM, a repeat temperature was taken and it was continuing to improve. There was no temperature values located in this document.R1's Discharge paperwork dated February 4, 2026, shows R1's rectal temperature upon discharge was 95.9 degrees F. (Rectal temperature=most accurate body temperature location. Normal rectal temperature=99.6-100.4 F)On February 9, 2026, at 12:03 PM, V10 Business Office Manager said V1 Administrator notified her that R1 was in the emergency room and V1 asked V10 if she could go to the emergency room to check on R1. V10 said she got to the emergency room a few minutes before 7:00 AM. V10 said R1 had been at the emergency room for about 54 minutes by the time she arrived. V10 said R1 slept after she ate breakfast while in the emergency department. V10 said R1 was hooked up to a heart monitor, and the hospital staff were monitoring R1's body temperature. V10 said hospital staff did an oral temperature which read 93 degrees F. The hospital staff were unsure if R1 had the thermometer under her tongue, so they took a rectal temperature which was 95.9 degrees F (an hour or more after resident arrived to the emergency department). V10 said R1 had 2-3 blankets on top of her and the hospital staff also placed a special blanket on top of R1 that blew warm air.On February 9, 2026, at 12:23 PM, V11 Nurse Practitioner said she heard that R1 exited the facility. V11 said that R1 used to be homeless before she became a resident of the facility. V11 said R1 would not be able to be on her own safely due to R1's cognition. V11 said residents should not be able to go out of a facility if the facility is secured. V11 said R1 was able to leave the facility with an escort: family or friend. V11 said residents with cognitive issues have an escort when they leave the facility for safety reasons. V11 said if a resident is found outside in temperatures less than 20 (degrees F), hypothermia would be a concern for her. V11 said a body temperature below 95 degrees (F) is considered hypothermia.On February 9, 2026, at 11:25 AM, R1 said she has been at the facility for Two weeks, I think. But I don't even have a room anymore. They took it away from me. When R1 was asked if she remembered when she went outside in the cold the other day, R1 said, I have no idea what you are talking about. R1 was asked if she ever goes outside, and R1 said, I go smoke a couple times a day. I just go out the front door when I want. R1 has not smoked since she has been a resident of the facility. When R1 was asked if she remembered going to the hospital, she said yes and that the hospital checked her out and sent her to the facility. R1 did not remember where she was picked up. R1 did not remember speaking with a police officer nor did R1 remember where she slept the night prior.The facility's Elopement and Wandering Residents Policy revised September 5, 2025, shows, This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement received adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. The facility is equipped with door (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	locks/alarms to help avoid elopements. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. Adequate supervision will be provided to help prevent accident or elopements.The Immediate Jeopardy that began on February 4, 2026, was removed on February 10, 2026, at 12:34 PM, when the facility took the following actions to remove the immediacy:All residents were reassessed for the elopement risks.All residents identified as high risk for elopement had care plans reviewed for accuracy. Elopement binder reviewed and updated to reflect high risk residents.An emergency QAPI was held on February 6, 2026, to review policies/procedures.Daily door alarm audits began February 4, 2026.Door alarm added to interior door leading to staff entrance on February 6, 2026.Second door alarms added to reception door as well as the exit between two units in order to double alarm all exits on February 6, 2026.Additional speakers added so alarms are more audible on February 6, 2026.In-Service/Education was initiated on February 5, 2026, on facility's door alarm protocol, responding to alarms, and completing head counts.R1 was moved to a secured unit on February 4, 2026.The Administrator or designee will perform elopement risk assessment audits five times per week for two weeks, then three times weekly for two weeks, then weekly for four weeks to ensure compliance with transfer protocols. Findings will be reviewed during Quality Assurance and Performance Improvement meetings monthly. Noncompliance will result in immediate corrective action and additional staff training. Monitoring will continue until the QAPI committee determines sustained compliance has been achieved.The Administrator or designee will perform door alarm response audits five times per week for two weeks, then three times weekly for two weeks, then weekly for four weeks to ensure compliance with transfer protocols. Findings will be reviewed during Quality Assurance and Performance Improvement meetings monthly. Noncompliance will result in immediate corrective action and additional staff training. Monitoring will continue until the QAPI committee determines sustained compliance has been achieved.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review the facility failed to administer medications as order for 3 of 5 residents (R1, R4 and R5) reviewed for pharmacy services in the sample of 12.The findings include:1.R4's January Medication Administration Record (MAR) shows an order dated 12/8/25 for, Muro 128 Ophthalmic Ointment 5%-Instill 1 application in right eye two times a day. The MAR shows that he did not receive it on 1/12 (PM dose) and 1/30 (AM dose) and 1/31 (AM dose). R4's February MAR shows that he didn't receive it on 2/1/26.R4's Order-Administration Note dated 1/12 shows, Solution available however responsible party/POA is awaiting the ointment as ordered. R4's Order-Administration Note dated 1/30, 1/31 and 2/1 shows, medication not available. On 2/9/26 at 10:41 AM, V12 (Registered Nurse) said that she has worked at the facility for two weeks and R4 has never had Muro ointment available to administer until just the other day. V12 said that she did call pharmacy but it never came. V12 said that she would just sign it out as administered even though she didn't have it because R4's mother had a supply of it. R4's January MAR shows an order dated 1/27/26 for Dextromethorphan-15 mg (milligrams)/5 ml (milliliters)-Give 5 ml by mouth three times a day for cough for 7 days. R4's MAR shows that he did not receive it on 1/28 for one dose and 1/29 for one dose. R4's Orders-Administration Notes for those dates shows, Medication not available.2.R1's Nursing Note dated 1/27/26 shows, Resident returned to facility at 1730 (5:30 PM), with new orders in stable condition.R1's January MAR shows and order dated 1/28/26 for, Magic Mouthwash (lidocaine/Maalox-give 15 ml by mouth four times a day for mouth sore ***Compounded by pharmacy-fax MD order to Pharmacy**. The MAR shows that she did not receive the medication for three doses on 1/28/26 and one dose on 1/29/26. R1's Pharmacy Proof of Delivery List from 1/1/26 to 2/5/26 shows that Magic Mouthwash was never delivered to the facility.On 2/9/26 at 12:01 PM, V11 (Nurse Practitioner) said that R1 was sent to the emergency room due to having blood all over in her mouth. V11 said the emergency room found out that she had bit her tongue and ordered the mouthwash for pain control. V11 said that she does not think that she ever received the mouth wash. V11 said that the mouth wash would have been ordered upon her return and delivered by the pharmacy. 3.R5's January and February Medication Administration Record shows that she receives Prazosin 2mg at bedtime for dreams. R5's MAR shows that she did not receive the medication on 1/2/26, 1/5/25 and 2/1/26. R5's Order-Administration notes for those dates show that it was on order. On 2/9/26 at 2:09 PM, V2 (Director of Nursing) said that all medications should be administered as ordered. V2 said that all medication should be ordered when they have a 2-3 day supply remaining. V2 said that if a nurse goes to administer a medication and it is not available, they should call the pharmacy to see when it is expected to be delivered and if it is not going to be delivered by the time that the medication is due, they need to call the pharmacy for a STAT delivery. V2 said that resident's should not have to go without their ordered medications. The facility's Medication Administration Policy revised on 9/1/24 shows, Reorder medications from the pharmacy when there is 2 to 3 day supply remaining.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review the facility failed to ensure significant medications were administered as ordered for 2 of 5 residents (R4 and R5) reviewed for medication administration in the sample of 12.The findings include:1.R5's Nurse Practitioner Note dated 2/5/26 shows that R5 was diagnosed with a pulmonary embolism (blood clot in the lung) on 11/4/25 and is to continue her Lovenox (Enoxaparin- an anticoagulant used to treat and prevent blood clots) 100 milligrams (mg) twice a day.On 2/5/26 at 1:07 PM, R5 said that she recently had a blood clot in her lung and was put on a blood thinner to prevent additional clots. R5 said that the facility is constantly running out of her medications. R1 said that she has missed multiple doses. R5's January Medication Administration Record (MAR) shows an order starting 1/2/26 for Enoxaparin Sodium Injection 100 mg/mL (milliliter)-Inject 100 mg subcutaneously two times a day for anticoagulant. R5's MAR shows that she did not receive a dose on 1/2/26 (PM dose), 1/19/26 (AM and PM dose), 1/20/26 (PM dose), and 1/26/26 (AM and PM dose). R5's Orders-Administration Notes for those dates document that the medication is on order.On 2/9/25 at 12:01 PM, V11 (Nurse Practitioner) said that R5 is on enoxaparin due to having a pulmonary embolism in November shortly after her motor vehicle accident. V11 said that she is on the medication to prevent any additional blood clots and to keep her previous one from getting worse. V11 said that it is important that she receives the doses as ordered. V11 said that R5 did tell her about the missing doses as well. 2.R4's January MAR shows that he receives levetiracetam 500 mg-3 tablets twice a day for anticonvulsant. R4's MAR shows that he did not receive his AM or PM does on 1/20/26 and his AM dose on 1/21. R4's Orders-Administration Note shows that the medication was not available. On 2/9/26 at 12:01 PM. V11 (Nurse Practitioner) said that R4 has a seizure disorder. V11 said that he is on levetiracetam to prevent seizures and should be given as ordered. V11 said that if he misses too many doses, he could have a seizure. V11 said that if a medication is not available, they should call her and let her know and she will direct them on what to do. V11 said that she was not aware that he missed any doses of his levetiracetam. On 2/9/26 at 2:09 PM, V2 (Director of Nursing) said that all medications should be administered as ordered. V2 said that all medication should be ordered when they have a 2-3 day supply remaining. V2 said that if a nurse goes to administer a medication and it is not available, they should call the pharmacy to see when it is expected to be delivered and if it is not going to be delivered by the time that the medication is due, they need to call the pharmacy for a STAT (immediate) delivery. V2 said that resident's should not have to go without their ordered medications. The facility's Medication Administration Policy revised on 9/1/24 shows, Reorder medications from the pharmacy when there is 2 to 3 day supply remaining.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on interview and record review the facility failed to ensure a respiratory viral panel was performed as ordered for 1 of 5 residents (R4) reviewed for laboratory services in the sample of 12.The findings include:R4's Nurse Practitioner Progress Notes dated 2/5/26 shows, Acute Cough. respiratory viral panel R4's Physician's Order Sheet shows an order dated 2/5/26 for a respiratory viral panel written by the prescriber. On 2/10/26 at 2:52 PM, V11 (Nurse Practitioner) said that R4 had a cough so she ordered a respiratory viral panel to make sure that he did not have a virus that was causing the cough. V11 said that she put the order into the computer and told the nurse as well. V11 said that she has not seen the results of the test and does not know if it was done or not. On 2/11/26 at 10:45 AM, V2 (Director of Nursing) said that if a provider orders a respiratory viral panel, the nurse should collect the specimen and notify the laboratory that the specimen needs to be picked up and fill out a laboratory requisition form. V2 said that she could not find any evidence that a specimen was collected and sent to the laboratory. The facility's Laboratory and Diagnostic Services and Reporting Policy revised on 9/1/24 shows, The facility must provide or obtain laboratory and diagnostic services when ordered by a physician, physician assistant; nurse practitioner or clinical nurse specialist in accordance with state law. The facility must provide or obtain laboratory and diagnostic services to meet the needs of its residents.The nurse will carry out laboratory and radiology orders per facility protocol. Promptly notify the ordering physician, physician assistant, nurse practitioner of laboratory and radiology results that fall outside the clinical reference range for appropriate follow-up/orders.

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. Based on interview and record review the facility failed to obtain a STAT (immediate) chest x-ray as ordered for 1 of 5 residents (R4) reviewed for radiology services in the sample of 12.The findings include:R4's Nurse Practitioner Progress Notes dated 2/5/26 shows, Acute Cough. Chest x-ray R4's Physician's Order Sheet shows an order dated 2/5/26 for a stat chest x-ray written by the prescriber. On 2/10/26 at 2:52 PM, V11 (Nurse Practitioner) said that R4 had a cough so she ordered a chest x-ray to make sure R4 did not have pneumonia due to his history of chronic bronchitis and pneumonia. V11 said that she put the order into the computer and told the nurse as well. V11 said that she has not seen the results of the x-ray and does not know if it was done or not. On 2/11/26 at 10:45 AM, V2 (Director of Nursing) said that if a provider orders a stat x-ray, the nurse calls the x-ray provider and orders the x-ray. V2 said that they typically come out and perform the x-ray within four hours. V2 said that the results are usually received that same day. V2 said that she could not find any evidence that a x-ray was performed. The facility's Laboratory and Diagnostic Services and Reporting Policy revised on 9/1/24 shows, The facility must provide or obtain laboratory and diagnostic services when ordered by a physician, physician assistant; nurse practitioner or clinical nurse specialist in accordance with state law. The facility must provide or obtain laboratory and diagnostic services to meet the needs of its residents.The nurse will carry out laboratory and radiology orders per facility protocol. Promptly notify the ordering physician, physician assistant, nurse practitioner of laboratory and radiology results that fall outside the clinical reference range for appropriate follow-up/orders.