

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146028	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/24/2026
NAME OF PROVIDER OR SUPPLIER Serenity Estates of Lincolnshire		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure staff reported an allegation of verbal abuse to the abuse coordinator for 1 of 3 residents (R1) reviewed for abuse in the sample of 6. The findings include: R1's admission Record showed she was admitted to the facility on [DATE] with diagnoses including, but not limited to chronic kidney disease stage 3, unsteadiness on feet, abnormal posture, abnormalities of gait and mobility, depression, insomnia, anxiety disorder, cognitive communication deficit, primary generalized osteoarthritis, morbid (severe) obesity, type II diabetes mellitus, anemia, and chronic peripheral venous insufficiency. R1's facility assessment dated [DATE] showed she was cognitively intact. The assessment showed R1 had no range of motion impairment to her bilateral upper and lower extremities and used a walker and wheelchair for mobility. Set up/clean up assist for meals. The assessment showed R1 required substantial/maximal assist for toilet hygiene, bathing, upper and lower body dressing, putting shoes on/off, bed mobility including rolling and going from a sitting to lying and lying to sitting on the side of the bed position, sit to stand position, transfers, and walking. On 3/20/26 at 8:31 AM, V19 (Insurance Case Manager) said she was in the facility talking with R1. V19 said she is R1's case manager for her insurance. R1 said V5 had verbally abused her by calling her fat and big. V19 said R1 is overweight and sensitive about her weight. R1 told V19 it happened several times and she was upset. No further information to provide. On 3/20/2026 at 10:11 AM, R1 was sitting in a wheelchair in her room. R1 was alert and oriented. R1 said the first day she was in the facility V5 (CNA) said You're so big to her. R1 said on days 3, 4 and 5, V5 said You're so fat. R1 said she told V10 and V18 (Certified Nursing Assistants (CNAs) and V9 (Licensed Practical Nurse-LPN) about what V5 said to her. R1 said she does not recall if she said anything to anyone else. R1 said she is sensitive about her weight. R1 said she does not see V5 anymore and she is not aware if he was fired or reassigned somewhere else. On 3/20/26 at 10:52 AM, This surveyor spoke with V1 (Administrator) about R1's allegations. V1 said she gave R1 her phone number and they have been communicating back and forth since 2/26/26. V1 said neither R1, nor have any staff said anything to her about V5 saying something about R1's weight. At 11:12 AM, V1 said R1 was recently admitted to the facility. V1 said she had not received any reports of verbal abuse. On 3/20/25 at 3:25 PM, V10 (CNA) said R1 never said anything to her about V5 calling her big or fat. V18 could not be interviewed as she was out of the country for a family member's funeral. On 3/24/26 at 2:02 PM, V9 (LPN) said R1 never said anything to her about V5 calling her big or fat. On 3/24/26 at 2:58 PM, V16 (CNA) said R1 told her a couple weeks prior that V5 was calling her fat. She did not say when it happened. V16 said it was a while ago that she told me that. A couple of weeks ago. I asked her if (V5) had apologized after he said that and she said no. She said she felt abused. V16 said she did not report it to anybody. V16 said if someone says they are being abused I should absolutely report it. I did not report it. I was just listening to her story. V16 said she remembers that R1 said that she had already told someone about it already, that is why she (V16) did not report it. V16 said it may have been a good idea to follow up with the (V1 Administrator) or (V4-Director of Nursing) to make sure they were aware. The facility's Abuse, Neglect, and Exploitation Investigation policy and (continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>procedure, with a review date of 2/27/2026, showed the facility is committed to ensuring all residents are free from abuse, neglect, exploitation, and misappropriation of property. All allegations, regardless of source or perceived severity, will be immediately reported, thoroughly investigated, and addressed. Ensure immediate resident safety and separate alleged victim and accused individual. Place accused staff member on administrative leave pending investigation. Notify Administrator, DON (Director of Nursing), RNC (Regional Nurse Consultant), and RDO (Regional Director of Operations) immediately.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to suspend a staff member accused of abuse when an allegation was reported for 2 of 3 residents (R1, R2) reviewed for abuse in the sample of 6. The findings include:1. R1's admission Record showed she was admitted to the facility on [DATE] with diagnoses including, but not limited to chronic kidney disease stage 3, unsteadiness on feet, abnormal posture, abnormalities of gait and mobility, depression, insomnia, anxiety disorder, cognitive communication deficit, primary generalized osteoarthritis, morbid (severe) obesity, type II diabetes mellitus, anemia, and chronic peripheral venous insufficiency. R1's facility assessment dated [DATE] showed she was cognitively intact. The assessment showed R1 had no range of motion impairment to her bilateral upper and lower extremities and used a walker and wheelchair for mobility. Set up/clean up assist for meals. The assessment showed R1 required substantial/maximal assist for toilet hygiene, bathing, upper and lower body dressing, putting shoes on/off, bed mobility including rolling and going from a sitting to lying and lying to sitting on the side of the bed position, sit to stand position, transfers, and walking. On 3/20/26 at 8:31 AM, V19 (Insurance Case Manager) said she was in the facility talking with R1. V19 said she is R1's case manager for her insurance. R1 said V5 had verbally abused her by calling her fat and big. V19 said R1 is overweight and sensitive about her weight. R1 told V19 it happened several times and she was upset. No further information to provide. On 3/20/2026 at 10:11 AM, R1 was sitting in a wheelchair in her room. R1 was alert and oriented. R1 said some of the staff don't want to lift my legs and swing them around to help me get in position to lie down, they complain about their back. R1 identified V6 and V7 as two of the staff that complain about their back when they have to help swing her legs around. R1 said the first day she was in the facility V5 (CNA) said You're so big to her. R1 said on days 3, 4 and 5, V5 said You're so fat.2. R2's admission record showed he was admitted to the facility on [DATE] with diagnoses including, but not limited to Parkinson's disease, type II diabetes mellitus. unsteadiness on feet, abnormal posture. Muscle weakness, cognitive communication deficit, Asperger's syndrome, obstructive sleep apnea, a personal history of malignant neoplasm of testis, a history of falling, anxiety disorder, depression, spasmodic torticollis (painful, chronic neurological movement disorder causing involuntary muscle contractions in the neck, resulting in abnormal head twisting tilting and jerking), restless leg syndrome, and chronic kidney disease stage 3A. R2's care plans showed he is a fall risk and needs staff assist for transfers. R2's progress notes showed R1 needs staff assistance for toilet hygiene, bathing, and lower body dressing, and transfers. On 3/19/26 at 4:49 PM, V20 (EMT) said he is an EMT that was called to transport R2 back to the facility from the ER. V20 said R2 had mentioned something in the ER about abuse at the facility. V20 said on the way back to the facility R2 said a female CNA was aggressive, and rough with care. He did not say who the female CNA was. He did not say when the incident occurred. On 3/20/26 at 9:27 AM, R2 said one of the female CNAs from the midnight shift is very aggressive, and rough with care. R2 described the female CNA as a large full-figured African American woman. R2 said when he is incontinent, she comes in and says what do you want. R2 said the unknown aide is jostling him around like a piece of meat. R2 said the unknown female CNA told him to go to sleep and quit using the call light. She said I was abusing call-light privileges. She was very abrasive. R2 said V5 (CNA) confiscated his remote and said he could only eat in his room. R2 said it happened in the afternoon on the previous Sunday. R2 said V5 was rough with helping him too. On 3/20/26 at 10:52 AM, This surveyor spoke with V1 (Administrator) about R1 and R2's allegations. V1 said she gave R1 her phone number and they have been communicating back and forth since 2/26/26. V1 said neither R1, nor any staff have said anything to her about V5 (CNA) saying something about R1's weight. V1 said no staff have reported to her that R1 voiced concerns about staff saying it hurts their back to lift her legs and swing them onto the bed for her to lay down. V1 said she has not had any reports of verbal abuse or of staff being rough. On 3/24/26 at 10:30 AM, V5 was sitting up at (continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>the nurses' station on the unit R2 resides. On 3/24/26 at 12:18 PM, V2 (Regional Director of Operations) said V5 is suspended until the investigation is completed. V2 said V1 (Administrator) misunderstood and did not realize the new allegations included V5. On 3/24/26 this surveyor was provided with V5's time clock entries. The document showed V5 worked a double shift on Saturday 3/21/26 and a double shift on Sunday 3/22/26. The document showed V5 worked on 3/24/26 from 6:42 AM - 11:10 AM before he was suspended. The facility's Abuse, Neglect, and Exploitation Investigation policy and procedure, with a review date of 2/27/2026, showed the facility is committed to ensuring all residents are free from abuse, neglect, exploitation, and misappropriation of property. All allegations, regardless of source or perceived severity, will be immediately reported, thoroughly investigated, and addressed. Ensure immediate resident safety and separate alleged victim and accused individual. Place accused staff member on administrative leave pending investigation. Notify Administrator, DON (Director of Nursing), RNC (Regional Nurse Consultant), and RDO (Regional Director of Operations) immediately.</p>		