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	04/29/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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 observation, interview, and record review the facility failed to ensure a cognitively impaired resident with a known history of elopement while at home did not elope from the facility for 1 of 3 residents (R1). This failure resulted in R1 exiting a secured unit and the facility unsupervised, walking approximately 1,000 feet and crossing a four-lane road in the dark until found by staff approximately 45 minutes later. The Immediate Jeopardy began on 4/19/26 at approximately 3:30 AM, when R1 exited from a secured unit, walked to a different unattended unit and past a nurse's station, down a hallway, and exited the facility unsupervised through a fire exit door. R1 then walked through the rear courtyard for approximately 350 feet, through the facility parking lot another approximate 200 feet, across a four-lane street in the dark, and was found by facility staff around 4:15 AM walking in a nearby shopping center parking lot approximately 1000 feet from where R1 exited the building. V1 (Administrator) was notified of the Immediate Jeopardy on 4/28/26 at 4:23 PM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on 4/28/26, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training, and dedicated staffing pattern.The findings include:R1's Facesheet dated 4/27/26 shows R1 admitted to the facility on [DATE] with diagnoses including, but not limited to, anxiety disorder, unspecified dementia with psychotic disturbance, major depressive disorder, paranoid personality disorder, and altered mental status. On 4/27/26 at 10:56 AM, R1 was sitting at a table in the dining room on the locked 700 unit. R1 was wearing a medium heavy jacket and tight-fitting walking shoes. R1 was unable to recall the events on 4/19/26 but quickly began experiencing both auditory and visual hallucinations including seeing a vehicle she stated was V6 (R1's Granddaughter) who was attempting to enter the facility and could not get in. R1 would also state that V6, who is pregnant, was telling R1 that V6 was going to lose the baby and didn't have any food. This increased R1's anxiety and aggression at attempting to exit the facility and make contact with V6. V8 (Business Office Manager) called V6 to have V6 speak to R1 to calm R1, but R1 went right back to experiencing auditory and visual hallucinations regarding V6 just minutes after getting off the phone with V6. On 4/27/26 at 9:58 AM, V1 (Administrator) said she was most concerned at the amount of distance R1 could travel away from the facility because R1 is a really good power walker. On 4/27/26 at 11:30 AM, V9 (Maintenance Director) said per the state building code, fire doors are required to remain locked for fifteen seconds once the door is attempted to be opened while the door alarm is armed. When the door is attempted to be opened, the alarm will sound immediately and remain on until staff disarm the alarm.On 4/27/26 at 11:30 AM, this surveyor noted R1 would have passed the 400 unit nurse's station in order to get to the fire exit door at the end of the hall. On 4/27/26 at 12:58 PM, V13 (Certified Nursing Assistant- CNA) said at the time the exit door fire alarm went off, V13 was on the 300 unit providing care to a resident and not on the 400 unit that R1 exited the building from.On 4/27/26 at 2:06 PM, V14 (Regional Director of Operations) said the facility will now add an additional CNA to the overnight shift. On 4/28/26 at 8:55 AM, V3 (Licensed Practical Nurse-LPN) said for the overnight shift, V3 covers multiple units, including the locked 700 (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 Note: The nursing home is disputing this citation.	unit that R1 resides on. On the overnight shift from 4/18/26 to 4/19/26, V3 was scheduled to cover the 700 unit, the 100 unit, and half of the 200 unit. The 100 and 200 units are on the west side of the facility, and the 700 unit is on East side of the North hallway of the facility. V3 said at the beginning of her shift, V3 did initial rounds on R1's unit and noted R1 to be sleeping. V3 then went onto the other units to do rounds. V3 returned to R1's unit around 2:00 AM. Around 3:30 AM when the 700 unit's door alarm went off, V3 was exiting another resident's room. V3 immediately checked R1's room knowing R1 is an elopement risk and noted R1 was missing. V3 then returned to the unit door where the alarm was sounding, exited, and continued down the hall and adjacent rooms searching for R1. V3 continued down the hall towards the main entrance and exited the main entrance, sounding the facility door alarm, alerting other staff. While out the main entrance, V3 called V11 (Registered Nurse- RN) to notify her that R1 was missing then proceeded to walk to the street. V3 went East about halfway down the building, then went [NAME] all the way to the traffic light and back to the main entrance without finding R1. At this time, the other staff were on their units conducting headcounts and looking room to room to try and locate R1. V3 and V11 looked through the facility together including checking the basement with no success. After finishing the first round of searching the facility V3 and V11 called V1 (Administrator) to notify her of the situation. V3 and V11 began going unit to unit again, conducting a second round search when they noted a door alarm going off on the non-locked 400 unit on the South-East side of the building. V3 stated the fire exit door in the back hall was open and V3 and V11 used flashlights from their phones to navigate the dark rear courtyard. First, V3 and V11 took a left out of the fire exit door, heading East, and searched that portion of the courtyard with no success. V3 and V11 then proceeded West, towards the parking lot. V3 said when they made it to the gate to the rear courtyard, the gate was ajar and R1 was nowhere to be seen. V3 and V11 headed towards the front of the building to take V3's car and search for R1. V11 sent a text message to V13 (CNA) and instructed V13 to take V13's car, head South of the facility and search the East side of the main busy four-way road (Route 21) while V3 and V11 would search the East side of the main busy four-way road (Route 21). V3 and V11 exited the parking lot to the facility and initially took a right and went all the way to the other end of the building. When not finding R1, V3 and V11 turned around, drove to the stop light, and took a left, heading South, onto the main, busy four-way road (Route 21). V3 and V11 then took the first right into a strip mall, located on the North-West corner of the intersection of the two main roads (Route 21 and Route 45), which includes a bank and restaurants. At approximately 4:15 AM, while driving past the bank, V3 noted R1 was walking by the entrance of the building adjacent to the bank. R1 was wearing a black jacket, pants and shoes. When V3 and V11 approached R1, R1 said, Oh my God, thank God you're here! Are you taking me home? R1 then told V3 and V11 that R1 wanted to go to V6's (R1's Granddaughter) birthday party. V3 and V11 assessed R1 after returning to the facility with no injuries or concerns.On 4/28/26 at 10:02 AM, V10 (RN) said at the time the main door alarm was activated by V3, V10 was on the 200 unit on the [NAME] side of the facility and not on the 400 unit R1 exited the building from. On 4/28/26 at 1:28 PM, V12 (CNA) said she worked the overnight shift from 4/18/26 into 4/19/26 on the locked 700 unit. V12 said R1's demeanor on the evening of 4/18/26 was actually pretty good. The last time V12 saw R1 was around 12:45 AM to 1:00 AM when V12 provided R1's roommate with a bedpan and R1 was sleeping in R1's bed. V12 said prior to the door alarm going off, V12 recalls V3 (LPN) sitting at the nurse's station on the locked unit. When the unit door alarm went off around 3:30 AM, V12 was in R7's room providing care and couldn't immediately respond to the door alarm. When V12 went to the door to see what was going on, V12 saw V3 running out the door. After finishing providing R7 care, V12 proceeded to conduct a head count on the unit. On 4/28/26 at 2:06 PM, V14 (Regional Director of Operations) said R1's hallucinations are family focused and early in the day on 4/18/26, R1's family had visited with R1 for an extended period of time which may have increased R1's agitation. R1's hospital documents from 3/30/26 show R1 was admitted to the local hospital for worsening agitation and paranoia delusions for several months. R1 was also exhibiting a behavior of fleeing and escaping from R1's home. V5 (R1's Husband) had to (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	monitor R1 at all times to prevent R1 from escaping.R1's psychiatric hospital documents from 3/30/26 shows R1 escaped from R1's home on 3/28/26 and was alone for several hours before the police found R1 and called V5.R1's progress note from 4/8/26 at 9:58 PM shows R1 is able to walk without assistive devices. R1's Elopement Risk assessment dated [DATE] shows R1 is at high risk of elopement stating Recent hx (history) wandering outside her room, paranoid delusions that someone is out to get her. Placed on elopement life for safety.R1's Care Plan initiated 4/12/26 shows R1 is an elopement risk and the only intervention is from 4/8/26 stating, Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book.R1's Progress Note from 4/14/26 at 9:12 PM states, Resident left unit and was redirected in the hallway by staff where she [R1] displayed physical aggression .Facility nursing schedule for 4/18/26 shows V13 and V10 were the only two staff scheduled to cover the 400 unit. Neither V13 nor V10 were on the 400 unit when R1 exited the facility. An online measuring tool was used to calculate the approximate distance that R1 traveled showing R1 traveled an approximate 1,000 feet from the fire exit door of the 400 unit, across a known busy four-lane road (Route 21), and into the parking lot that R1 was found. The Facility Elopements and Wandering Residents policy revised 9/5/25 states, This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering and elopement risk.The facility presented an abatement plan to remove the immediacy on 4/29/26 at 8:30 AM. The survey team reviewed the abatement plan and was unable to accept the plan to remove the immediacy. The abatement plan was returned to the facility for revisions. The facility presented a revised abatement plan on 4/29/26 at 10:59 AM. The survey team reviewed the revised abatement plan and was unable to accept the plan to remove the immediacy. The abatement plan was returned to the facility for revisions. The facility presented a revised abatement plan on 4/29/26 at 11:34 AM. The survey team reviewed the revised abatement plan and was unable to accept the plan to remove the immediacy. The abatement plan was returned to the facility for revisions. The facility presented a revised abatement plan on 4/29/26 at 11:59 AM. The survey team reviewed the revised abatement plan and was unable to accept the plan to remove the immediacy. The abatement plan was returned to the facility for revisions. The facility presented a revised abatement plan on 4/29/26 at 12:20 PM, and the survey team accepted the abatement plan on 4/29/26 at 12:20 PM.The Immediate Jeopardy that began on 4/19/26 was removed on 4/28/26 when the facility took the following actions to remove the immediacy:All resident elopement assessments reviewed and up to date as of 4/20/26, and reviewed again on 4/28/26. All residents identified as a high risk for elopement had care plans reviewed for accuracy by 4/20/26, and reviewed again on 4/28/26. Elopement binder reviewed and up to date to reflect high risk residents by 4/20/26 and reviewed again on 4/28/26. An emergency QAPI was held to review policies/procedures, and final investigation notes, on 4/20/26. Daily door alarm audits completed beginning 4/20/26. An in-service education process was initiate on April 19, 2026. The Administrator is responsible for providing education and expectations to all managers and supervisors. In collaboration, the Administrator, managers, and supervisors will ensure re-education on the elopement policy is provided to all department staff as they return to work to verify understanding and ongoing compliance with facility policies and procedures. R1 provided with 1:1 staff and/or increased supervision as needed effective 4/19/2026.Ensure a dedicated staff is scheduled on each unit. The HR (Human Resources) director will ensure there will be a dedicated staff on each unit. The administrator or DON (Director of Nursing) will audit compliance.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review the facility failed to adequately schedule staff to ensure all units were attended during the overnight shift. This has the potential to effect all 128 residents residing in the facility during the overnight shift. The findings include: Facility Data Sheet shows there are 128 residents residing in the facility as of 4/27/26. Facility provided nursing schedule from 2/27/26 to 4/27/26 shows the facility staffs the overnight shift with three nurses and six certified nursing assistants (CNAs) to cover seven units. Facility nursing schedule from 4/18/26 shows the 700 unit had a census of 23, the 100 unit had a census of 11, and the 200 unit had census of 16. V3 (Licensed Practical Nurse- LPN) was scheduled to cover the 700 unit, the 100 unit, and half of the 200 unit totaling 42 residents. This is a nurse to resident ratio of one to 42.Facility nursing schedule from 4/18/26 shows the 300 unit had a census of 20, the 400 unit had a census of 13, and the 200 unit had census of 16. V10 (Registered Nurse- RN) was scheduled to cover the 300 unit, the 400 unit, and half of the 200 unit totaling 41 residents. This is a nurse to resident ratio of one to 41.Facility nursing schedule from 4/18/26 shows the 500 unit had a census of 21 and the 600 unit had census of 16. V11 (RN) was scheduled to cover the 500 and 600 units totaling 44 residents. This is a nurse to resident ratio of one to 44.Facility nursing schedule from 4/18/26 shows the 100 unit had a census of 11, the 200 unit had a census of 16, the 300 unit had a census of 20, and the 400 unit had a census of 13. The schedule shows three CNAs are scheduled to cover those four units, providing each CNA with a staff to resident ratio of approximately one to 20. Facility nursing schedule from 4/18/26 shows the 500, 600, and 700 units each have their own scheduled CNA with unit census of 20 or more on each unit. On 4/27/26 at 12:58 PM, V13 (CNA) said it is normal to split the four units with only three CNAs and they try and split it so each CNA has 20 residents each. V13 said it would be better to have one CNA per unit because there is a lot of distance between some of the units. When you are on one unit, you can't see what's going on with the other unit.On 4/28/26 at 11:10 AM, V15 (Human Resources Director) said the current staffing pattern is the same staffing pattern the facility has followed for a while. V15 did say the 400 unit could use a full time nurse on all shifts, seven days a week, but it's not V15's decision to make. The Facility Assessment updated 4/1/26 states, The purpose of the assessment is to evaluate the resident population and determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Use this assessment to make decisions about your direct care staff needs (including those who provide services under contract and volunteers), as well as your capabilities to provide services to the residents in your facility, at least annually and as necessary, per the above requirement. Using evidence-based, data driven methods focuses on ensuring that each resident is provided care that allows the resident to maintain or attain their highest practicable physical, mental, and psychosocial well-being. The assessment also shows direct care staffing ratios for licensed staff should not exceed a ratio of one staff member to 30 residents for the overnight shift and it shows for certified staff the ratio should not exceed a ratio of one staff member to 18 residents for the overnight shift.