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	05/13/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to notify a resident's family of a room change for 1 of 4 residents (R1) reviewed for notification in the sample of 7.The findings include:On 5/12/26 at 1:01 PM, V21 (R1's daughter) said she came in on a Sunday and R2 had been moved into a different room (room [ROOM NUMBER]-B). V21 said the nurse told her R2 had an argument with his roommate Friday night and they moved him to the new room. V21 said she had gone to R2's old room (room [ROOM NUMBER]-B) and R2's personal items were still in that room. V21 said she was upset that no one had called her and they hadn't even moved all of R2's things to the new room, she had to do it. R2's Census List dated 5/13/26 shows on 4/10/26, R2 moved into room [ROOM NUMBER]-B.R2's Progress Notes do not contain documentation on or before 4/10/26 that V21 was notified or the reason for the room change.On 5/13/26 at 10:00 AM, V16 Social Service Director said R2 was moved to room [ROOM NUMBER]-B because of an issue with the roommate and R2 not getting along. V16 said the nurse asked for an available room and she told them the room that was available. V16 said that was all of the involvement she had with the move. V16 said the nurse should have called R2's daughter and let her know about the room change. V16 said there should have been a progress note charted as well regarding the details of the move. On 5/13/26 at 12:30 PM, V2 Director of Nursing said she was not involved with R2's room change on 4/10/26 and was not aware of the reason for the change. V2 said family should be notified of a resident's room change.The facility's Change of Room or Roommate Policy dated 9/1/24 shows Prior to making a room change or roommate assignment, all person involved in the change/assignment, such as residents and their representatives, will be given advance notice of such a change as is possible.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on observation, interview, and record review the facility failed to thoroughly investigate an allegation of abuse for 1 of 7 residents (R3) reviewed for abuse in the sample of 7. The findings include: On 5/11/26 at 1:40 PM, R3 was sitting on the bench seat of her rolling walker in the hall outside of her room. R3 said about a week ago on a Friday she was in the dining area before breakfast with a cup in her hand. R3 said V7 Certified Nursing Assistant took the cup out of her hand and accidently scratched the top of her hand with his fingernail. R3 said it was bleeding and she was upset. R3 said V8 Registered Nurse took care of the cut and put a band aid on it. R3 showed this surveyor the top of her right hand which had a band-aid still in place. R3 said it was healed and removed the band aid. R3's right hand had a healed skin tear in the shape of a half circle approximately the size of a half of quarter. On 5/11/26 at 3:08 PM, V7 said he had come in early for his 7:00 AM shift and was preparing the breakfast trays in the dining room. V7 said R3 was heading out of the unit doors with her walker and set off the alarms. V7 said V8 told him to get R3 back into the unit and he went to the unit entry door and called for R3 to come back that V8 needed to see her. V7 said R3 came back to the unit, and he went back to preparing trays. V7 said R3 told V8 that he scratched her and R3 said she was going to have me fired. V7 said he didn't even touch R3, he just held open the door to the unit for her to come back in. V7 said he was interviewed about what happened, but they didn't ask him about taking a cup out of R3's hand.On 5/12/26 at 9:31 AM, V8 said V7 was in the dining room fixing meal trays when the alarm went off for the unit door. V7 said she saw that R3 was in the hall and asked V7 to get her. V8 said she stepped away and when she came back, R3 was crying about a skin tear on her right hand. V7 said she was not interviewed about what happened with R3.On 5/12/26 at 10:51 AM, V3 Regional Nurse Consultant said V1 Administrator did the investigation and should have interviewed R3 and the staff involved. V3 said she interviewed R3 and R3 had told her the same story regarding the cup taken out of her hand by V7 and being scratched. V3 said R3 said the scratch was bleeding and V8 had taken care of it. On 5/12/26 at 9:20 AM, V2 Director of Nursing said V1 is no longer working at the facility, and she doesn't know anything about the investigation.The facility's Abuse Investigation for R3's allegation does not contain an interview with V8 or any other staff working at that time. V7's interview does not include any information about R3's story with the cup being taken out of her hand when the scratch occurred. On 5/12/26 at 12:15 PM, V4 Corporate Administrator said an Abuse Investigation should include an interview with the person making the allegation, anyone mentioned in the allegation (staff or residents) and anyone that would have information about the allegation. The facility's Abuse, Neglect, and Exploitation Policy dated 10/24/24 shows Investigation of Alleged Abuse, Neglect, and Exploitation: Identifying and interviewing all involved persons, including alleged victim, alleged, perpetrator, witnesses, and others who might have knowledge of the allegation.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review the facility failed to conduct a post fall analysis to ensure fall interventions were appropriate for a resident's self-reported fall for 1 of 3 residents (R1) reviewed for safety in the sample of 7.The findings include: On 5/12/26 at 1:10 PM, V21 (R1's daughter) said she came in to visit her dad, and he told her he had fallen and his back hurt. V21 said she lifted her dad's shirt, and he had a bruise on the left lower side of his back and a scrape on his left elbow. V21 said she went to the nurse on duty V17 Licensed Practical Nurse and asked her why no one called her about her dad falling. V21 said V17 had no idea that her dad fell and then asked R2 why he didn't tell her he fell. V21 said V17 told her she would get someone to send R2 to the emergency room, but V21 declined. V21 said approximately 10 minutes or so later, R2's dinner tray arrived and R2 began eating. V21 said V17 came and wanted to do an assessment on R2. V21 said she told V17 to wait until after R2 finished eating. V21 said V17 never came back to assess R2 so she went to talk to V2 Director of Nursing. V21 said she reported to V2 that R2 said he had fallen and no one knew about it. V21 said V2 offered to send R2 to the emergency room but she declined the need for an emergency room visit. V21 said V2 made her feel like she was bothering her with this concern. V21 said she then took her dad outside to enjoy the weather and V13 Certified Nursing Assistant (CNA) came out to say hello. V21 said she told V13 that R2 had fallen and showed her R2's bruise on his back. V21 said no one spoke to her about the fall, what happened, or what they were going to do about it.On 5/12/26 at 3:05 PM, V13 CNA said she had taken care of R2 when he was on another unit and knew V21 as well. V13 said V21 was visiting with R2 on the patio, and she had gone out to say hello. V13 said V21 told her about R2 falling and said he had a bruise on his back. V13 said V21 lifted R2's shirt and R2 had a greenish bruise on the left side of his back. V12 said R2 told her he fell. V13 said V21 was upset that no one knew about it.On 5/13/26 at 10:37 AM, V17 said R2 had been in the unit for a few days, when V21 approached her and said something about R2 falling. V17 said she asked R2 how he fell and he didn't know and was not able to answer how he got up or if anyone helped him. V17 said V21 refused for her to do anything. V17 said she should have charted the fall and the events. V17 said she didn't look at R2's back or elbow and could not remember if she told anyone about the fall.On 5/13/26 at 10:40 AM, V23 CNA (regular CNA for R2's unit) said he didn't know anything about R2's fall, but R2 had been complaining about back pain. V23 said he didn't see any bruise on R2, but R2 didn't require too much assist to dress his upper body, and he had not given R2 a shower during his shifts.On 5/13/26 at 12:30 PM, V2 said she never met V21. V2 said she didn't know anything about R2's fall and V17 had never talked to her about it. V2 said if a resident falls the nurse does a full body assessment with vital, skin check, and a pain assessment. V2 said the doctor is notified for orders and the family is called. V2 said the nurse does a risk management form which documents the events of the fall and the assessment findings. V2 said if family refuses to be sent out or refuses an assessment than that should be documented as well. R2's Progress Notes or Assessments do not contain documentation regarding R2 having a fall or sustaining any injury. R2's Care Plan dated 3/26/26 shows R2 is a high risk for falls related to vascular dementia with behavioral disturbances, anxiety disorder, frontotemporal neurocognitive disorder, and gait abnormality. Benefits from staff assistance with transfers, toileting assistance, and activities of daily living cares. History of fall incidents related to poor safety awareness and cognitive impairments. This same Care Plan was not updated during R2's stay (3/25/26-4/27/26).The facility's April 2026 Incident List does not contain any incidents involving R2.The facility's Incidents and Accidents Policy dated 9/1/24 shows It is the policy of this facility for staff to utilize the computer risk management to report, investigate, and review any accidents or incident that occur or allegedly occur, on facility property and may involve or allegedly involve a resident. The purpose of incident reporting can include: Assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve the management of resident care.

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a resident was free from significant medication errors for 1 of 4 residents (R1) reviewed for medications in the sample of 7. This failure resulted in R2 receiving a double dose of an antipsychotic medication for 33 days.The findings include:On 5/12/26 at 1:10 PM, V21 (R2's daughter) said she was visiting R2 one evening around 7:00 PM and the nurse on duty was giving R2 his evening medications. V21 said she inquired about the medications being given and found out that R2 was receiving 200mg of quetiapine fumarate instead of 100mg. V21 said she asked the nurse who authorized the change to 200 mg at night and the nurse did not know. V21 said she went to V2's Director of Nursing office and asked why her dad's medication dose was changed. V21 said V2 told her she had no idea and looked in the computer. V21 said V2 told her that he must have come from the previous facility on that dose. V21 said that there was no way he was on that dose at that facility and she had gone over the medications with the nurse upon admission. V21 said V2 told her she would have to contact the hospital and see if they had changed the dose. V21 said she had reached out to R2's neurologist via my chart and the neurologist reported he had not made a change to R2's dose of quetiapine fumarate. V21 said she reported this information back to the facility. V21 said she felt like her dad was declining during his stay there and they even had to move him into the secured dementia unit due to his increased wandering. V21 said toward the end of R2's stay, she would find R2 just sitting by himself staring off into the distance.R2's admission Medication List from R2's previous facility dated 3/20/26 shows quetiapine fumarate 50 mg 1 tablet in daytime; 2 tablets at bedtime.R2's Physician Orders shows R2 was admitted on [DATE] and shows order quetiapine fumarate 50 mg Give 1 tablet by mouth one time a day and quetiapine fumarate 100 mg Give 2 tablets by mouth at bedtime (total dose 200 mg).R2's Medication Administration Record (MAR) for March 2026 shows R2 received 200 mg of quetiapine fumarate at bedtime from 3/25/26 to 3/31/26 (7 days).R2's MAR for April 2026 shows R2 received 200 mg of quetiapine fumarate at bedtime from 4/1/26 to 4/26/26 (26 days).On 5/13/26 at 11:42 AM, V20 Nurse Practitioner said she did not give any orders to increase quetiapine fumarte which is an antipsychotic. V20 said she would have consulted with psychology before making a change in that medication and there was nothing in her notes about changing that medication. V20 said it is important to ensure admitting medications are correct for the resident to make sure the resident is cared for appropriately, make sure the resident's medical diseases are treated, and to prevent re-admission to the hospital. V20 said doubling a dose of an antipsychotic could increase the risk for side effects such as sleepiness, lethargy, confusion, and increase the risk for extrapyramidal side effects. On 5/12/26 at 12:30 PM, V2 Director of Nursing said she never met R2's daughter and did not have any conversations regarding R2's medications. V2 said upon admission the nurse reviews the admitting order from the hospital or facility and then calls the doctor. V2 said the nurse does a read back going over the medications and gets orders to continue or discontinue the medications. V2 said the next day the clinical team reviews the new admission admitting orders for errors. V2, when asked how this error was missed said human error.The facility's Medication Administration Policy dated 9/1/24 shows Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Ensure that the six rights of medication administration are followed: Right resident, right drug, right dosage, right route, right time, right documentation.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observation, interview, and record review the facility failed to be administered in a manner to ensure supplies were available for dependent residents for 1 of 3 residents (R2) reviewed for administration in the sample of 7. The findings include: On 5/11/26 at 1:15 PM, R2 was in bed dressed in a t-shirt and an incontinence brief. R2 said the facility has no briefs and has been out for a couple days. R2 said he wears the green XL size which is the most comfortable for him. R2 said he had a few in his closet but has been wearing them wet to make them last longer. R2 said they are uncomfortable to wear wet, but he has to make them last. R2 said they told him they were waiting on a delivery. R2's closet did not contain any incontinence briefs. On 5/11/26 at 1:35 PM, V5 Certified Nursing Assistant (CNA) said they are out of the green incontinence (XL) brief. V5 said he worked the weekend and they were out then as well. V5 said they have a few pull up briefs but not the ones R2 uses. V5 showed this surveyor the unit supply closet which contained a few pull up incontinence briefs, and three white incontinence briefs (small size). V5 said when they need supplies, he tells the nurse who tells the Director of Nursing.On 5/11/26 at 1:55 PM, V2 Director of Nursing said there was a supply order in, and it should be delivered Wednesday. V2 said they order supplies based on the census and the need. V2 said if they run out of something they can run to a local store and get supplies. V2, with this surveyor, went into the central supply room of the facility. V2 pointed to several empty pallets against one wall and said this is where the briefs are kept. There was one opened box of pull up incontinence briefs containing 3-4 pulls ups on one of the pallets, the rest were completely empty. V2 said she thought they went to the store on Friday, but she was not aware they were out. V2 said the Nurses or CNAs let her know. When asked who is in charge of ordering supplies, V2 said it is supposed to be the Scheduling Coordinator, but they don't have one, so it falls on her. V2 said residents should have the size incontinent briefs that fit and are comfortable for them. On 5/11/26 at 2:30 PM, V4 Regional Administrator said the facility should not run out of supplies, the administrator should make sure there is supplies and get some from local stores if needed. The facility's Central Supply Policy dated 9/1/24 shows It is the policy of the facility to ensure adequate quantities of supplies are provided to ensure ongoing care of the residents.