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	06/23/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure daily weight was performed as ordered for a resident with congestive heart failure (CHF). This failure resulted in R1's worsening heart failure condition causing fluid retention and shortness of breath requiring hospitalization for 1 of 3 residents (R1) reviewed for care and services in the sample of 3.The findings include:R1's electronic face sheet shows R1 was admitted to the facility with diagnosis that includes congestive heart failure.R1's Physician Order Sheet dated 5/20/26 show, monitor weight daily before breakfast. Notify MD of a 2 pounds (lbs.) weight gain in one day or 5 lbs. weight gain in one week.R1's Physician Order Sheet dated 5/20/26 shows, R1 was also on diuretics related to acute and chronic congestive heart failure. Spironolactone Oral Tablet 25 milligrams (mg) Give 1 tablet by mouth one time a day. Bumetanide Tablet 2 mg, Give 1 tablet by mouth two times a day. Furosemide Tablet 20 mg, Give 1 tablet by mouth one time a day. R1's Medication Administration Record for May and June 2026 showed he received all ordered diuretics.R1's medical record showed R1 was admitted on [DATE] and discharged to the hospital on 6/9/2026. (R1 resided at the facility for 26 days.)R1's weight record shows R1 was weighed one time (5/21/26) while at the facility. R1's weight was 420.5 lbs. (R1 was weighed only one time during his 26 day stay.)R1's weight record did not show an admission weight 5/15/26. R1 was not also weighed on 5/22, 5/23, 5/24, 5/25. 5/26, 5/27, 5/28, 5/29, 5/30,5/31, 6/1, 6/2, 6/3, 6/4, 6/5, 6/6, 6/7, 6/8 and 6/9.R1's facility assessment dated [DATE] did not show any behavior of R1 refusing to be weighed.R1's Emergency Department (ED) Hospital records dated 6/9/26 show [R1] presents to emergency department complaining of progressive weight gain, leg swelling and shortness of breath. Patients require 6 liters (l) of oxygen (upon arrival at the hospital). In the ED, chest x-ray shows cardiomegaly and pulmonary edema. R1 was given IV diuretics and admitted for further care. R1's admitting diagnosis of volume overload, c/f (concern for) heart failure exacerbation (worsening of CHF.) Treatments; diuretics and daily weights.The same hospital records documents that R1 was discharged to the skilled nursing facility after treatment of CHF last 5/15/26 with a weight of 389 lbs. R1 was readmitted from the skilled facility to the hospital last 6/9/26 with a weight of 439 lbs. now returns with 50 lbs. weight gain since discharge to the skilled facility last 5/15/26. The hospital records also show, per [R1] they mismanaged his care and the weight he lost prior to going to the skilled nursing, reaccumulated over the last several weeks. R1 with abdominal distention, lower extremities edema and shortness of breath.On 6/23/26 at 9:50 AM, V3 (License Practical Nurse-LPN) said she was one of R1's nurses. R1 was alert and able to verbalize his needs. Last 6/9/26, R1 requested to be sent out due to complaints of discomfort. R1 was still at the hospital at this time. R1 has CHF, he was supposed to be weighted daily, R1 was on water pills. On 6/23/26 at 11:32 AM, V2 (Director of Nursing) said R1 was admitted in May, coming from the hospital after being treated with CHF. On 6/9/26 R1 requested to go to the hospital. R1's SBAR (change of condition documentation) was incomplete because it was R1 who insisted on going (to the hospital). R1 was admitted and still at the hospital at this time due to heart failure decompensation. (Heart failure had gotten worse.) R1 was on diuretics. This surveyor and V2 DON reviewed R1's weight record while at the facility. V2 confirmed that while R1 was at the facility, R1 was weighed only once (5/21/26) when (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 0684 Level of Harm - Actual harm Residents Affected - Few	R1 was supposed to be weighed daily. V2 said weight monitoring is very important for residents with CHF on diuretics to detect fluid retention that may lead to worsening heart failure.On 6/23/26 at 1:30 PM, V4 (Physician Assistant) said residents with CHF especially on diuretics (water pills) require ongoing monitoring including daily weights measurements to identify fluid retention, changes in condition that may indicate worsening of heart failure that requires timely intervention.On 6/23/26 at 1:45 PM, V7 (R1's family) said R1 was still hospitalized and undergoing treatment to stabilize his condition (CHF).On 6/23/26 at 2PM, V1 (Administrator) said the facility has no policy addressing CHF care.