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	04/24/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34891 Based on observation, interview, and record review the facility failed to ensure pressure relieving interventions were in place for 2 of 5 residents (R58, R47) reviewed for pressure ulcers in the sample of 62. The findings include: 1. R58's face sheet printed on 4/23/25 showed diagnoses including but not limited to hypoglycemia, tremors, anxiety disorder, schizophrenia, and mild cognitive impairment of unknown etiology. R58's facility assessment dated [DATE] showed staff assistant required for toilet hygiene, transfers, and bed rolling. The same assessment showed R58 is always incontinent of urine and bowel. R58's pressure ulcer risk assessment dated [DATE] showed a moderate risk. R58's order summary report showed an order dated 8/9/23 for a low air loss mattress on the bed. R58's most recent weight dated 4/4/25 showed 111.4 pounds. On 4/22/25 at 11:46 AM, R58 was in bed and lying on her back. R58 said she had a sore on her upper buttock in the past but she thought it was healed. R58 said she never gets out of bed, and she uses an adult brief for incontinence. R58 was lying on a low air loss mattress and the dial setting was turned past the 350-pound mark. On 4/23/25 at 10:00 AM, R58 was in bed and asleep. The air mattress dial setting was still at the highest level of 350-pounds. At 1:49 PM, V9 (WCN-Wound Care Nurse) stated R58 does not have any wounds right now. She had a problem with her backside in past. R58 does not like to turn or get out of bed. She insists on staying in bed all the time and in the same position. She is thin and does not have a lot of body fat to help pad her back areas. V9 said the mattress setting is related to the weight of a resident. It should be set at the current weight. Too high of a setting will cause high pressure and the risk of skin breakdown. Too low of a setting prevents the mattress from doing its job. On 4/23/25 at 1:59 PM, V9 (WCN) viewed the air mattress setting on R58's bed and said it was wrong. The 350-pound mark is set way too high and the static button should not be on. It is too firm for her and it even feels overly firm by my hand. V9 confirmed R58's most recent weight was 111.4 pounds. V9 said the setting should be checked every shift, especially with her refusals of turning and not getting out of bed. V9 stated the floor nurse (V10) would be able to supply more details. (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/25 at 2:09 PM, V10 (Registered Nurse) stated R58's air mattress is adjusted based on her preferences. She will dictate how hard or soft she wants it. She gets upset if we turn it too hard so we soften it to how she likes it. V9 (WCN) was present and stated, No, that is wrong. She does not get to decide how the mattress should be set. V9 and V10 rolled R58 to her side and opened her incontinence brief. The brief was wet with urine and an egg size, red area was present on the coccyx. V9 stated this looks like the start of another pressure ulcer. R58's wound assessment dated [DATE] (day identified) showed a 2.0 x 5.5 centimeter, stage 1 pressure ulcer located on the coccyx. R58's care plan showed a focus area related to history of a sacrum DTI (deep tissue injury) noted on 12/4/24. Interventions included: Check air mattress if functioning properly every shift and prn (as needed). The facility supplied Low Air Loss Mattress System user manual states under the operating instructions: 9. Turn the Pressure Adjust Knob to set a comfortable pressure level using the weight scale as a guide. 20042 2. On 4/22/25 at 10:54 AM, R47's was in bed sleeping on her left side. R47's left leg was tucked under her. The side of R47's left ankle, foot and heel was in direct contact with the bed. R47 had a dressing to her left foot. R47 did not have and offloading boot in place to her left foot. At 11:00 AM, V13 CNA was asked to come to the resident's room. V13 stated she was R47's CNA for the day. V13 was asked to check the resident for offloading to her heels. V13 showed that there was an offloading boot in place to her right heel and foot. V13 removed the boot and the resident had a gauze dressing to her right foot. R47's left leg was contracted at the knee and she was laying on her left side. V13 was asked if the resident had an offloading boot for the left foot and she replied the resident did not have one on and she did not see another one in the room. The other offloading boot was visible on the bottom shelf of the nightstand. V13 pointed out the offloading boot, said she didn't see it over there. R47 stated she did not know why R47 had the offloading boots. V13 stated R47 is on hospice and has wounds to her feet. V13 stated she thought the boots were for the protection of R47's feet. On 4/22/25 at 11:18 AM, V14 Licensed Practical Nurse (LPN) stated R47 has wounds to her left big toe, right big toe, right hip, left lower extremity (medial side), sacrum, right back, and left fifth toe. On 4/24/25 at 11:21 AM, V8 LPN stated, R47 has heel boots because she has wounds and she is supposed to have them on; they are for prevention. V8 fills in at times as the wound nurse. The Care Plan dated 2/24/25 for R47 showed R47 has a pressure injury to left 5th toe related to immobility. Offload feet with heel protector or pillows. R47's Care Plan was updated on 3/31/25 showed she has a pressure injury to the left outer ankle related to immobility and fragile skin. Offload the site by using heel boot. R47's Minimum Data Set (MDS) dated [DATE] showed substantial/maximal assistance for personal hygiene; rolling left and right; dependent for sit to lying, lying to sitting, and transfers. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician Order Review Report dated 4/24/25 for R47 showed wound treatments to a left fifth toe deep tissue injury, unstageable right lateral back wound, left great toe wound, left lower medial leg wound, sacral wound and right hip wound. The Face Sheet dated 4/24/25 for R47 showed diagnoses including rheumatoid arthritis, pressure ulcer, chronic obstructive pulmonary disease, anemia, congestive heart failure, and muscle weakness. The facility's Pressure Injury Prevention and Management policy (9/1/24) showed, this facility is committed to the prevention of avoidable pressure injuries, unless unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34491 Based on observation, interview and record review, the facility failed to ensure the safety of a resident while smoking for 1 of 2 residents (R33) reviewed for smoking in the sample of 62. The findings include: R33's Admission Record, provided by the facility on 4/24/2025, showed she had diagnoses including, but not limited to, anxiety disorder, major depressive disorder, chronic pain syndrome, immobility syndrome (paraplegic), localized edema, bipolar disorder, nicotine dependence, and alcohol abuse. R33's care plan initiated on 3/26/2025 showed she is a smoker and expresses the desire to smoke at the facility. The care plan showed R33 had been assessed according to facility policy and had been determined to be a safe smoker, capable of following the applicable rules. The care plan showed Educate the resident concerning . not giving or trading cigarettes to peers, and the health and safety-related risks associated with smoking. On 4/24/2025 at 10:12 AM, R33 was sitting in her wheelchair outside in the courtyard. R33 was smoking a cigarette and stated she comes out anytime she wants to, even at night. R33 said staff do not check on her. R33 said she is allowed to keep her cigarettes and lighter with her. R33 said she puts them on top of the table in her room and just leaves them out. R33 complained about a female resident wandering into her room one day and took an expensive bottle of perfume from her room. On 4/24/2025 at 11:38 AM, R33 was sitting outside with two other residents smoking. No staff were present. A female resident reached into R33's bag, next to R33 in the seat of her wheelchair and grabbed a cigarette. R33 jokingly made a gesture towards the female resident and they both laughed. At 11:39 AM, R33 started crying and yelling help me. R33's hands were shaky. R33 had a cigarette in her hand at the time. R33 said help me two more times. No staff were present in the courtyard where the residents were smoking, and no staff went out to check on R33. After about 30 seconds, R33 stopped crying and calling for help, and went back to smoking and talking with the other two residents. At 12:02 PM, R33 was still outside smoking with the female resident with no staff present. At 1:30 PM, R33 and 2 other female residents were outside smoking with no staff present. On 4/24/2025 at 2:23 PM, V2 (Director of Nursing-DON) said resident's that have shaking, and are yelling out for help while outside smoking, should be reassessed for safety. If a resident is outside yelling for help, staff should be checking on them to make sure they are ok. V2 said smoking supplies (cigarettes and lighters, etc.) should not be left out where other residents have access to them. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R33's care plan initiated on 3/26/2025 showed she is at high risk for falls related to an unspecified injury of right foot, immobility syndrome (paraplegic), localized edema, anxiety disorder, and bipolar disorder. R33's facility assessment dated [DATE] showed she is cognitively intact. the assessment showed R33 had been having trouble concentrating on things, such as reading the newspaper or watching television, and moving or speaking so slowly that other people could have noticed, or the opposite-being so fidgety or restless that she had been moving around a lot more than usual (the assessment did not specify which of these symptoms were present). The assessment showed R33 experienced these problems several days (2-6 days) over the 2-week period reviewed for the assessment. The assessment showed R33 used a wheelchair for mobility and required substantial/maximal assistance of staff for dressing, bathing, toileting, and transfers. R33's Order Summary Report, provided on 4/24/2025, showed she receives anxiety medications, antipsychotic medications, anticoagulant medications, and pain medications. R33's 3/26/2025 Smoking Risk assessment showed she likes to smoke in the morning, afternoon, and evenings. The assessment showed R33 did not need adaptive equipment such as a smoking apron or cigarette holder, or supervision. The assessment showed R33 did not need the facility to store her lighter and cigarettes. The facility's 9/1/2024 policy titled Resident Smoking showed it is the policy of the facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and non-smoking residents .6. Residents who smoke will be further assessed, using the Resident Safe Smoking Assessment, to determine whether supervision is required for smoking, or if resident is safe to smoke at all .8. Any resident who is deemed safe to smoke, with or without supervision, will be allowed to smoke in designated smoking areas (weather permitting), at designated times, and in accordance with his/her care plan. 9. If a resident who smokes experiences any decline in condition or cognition, he/she will be reassessed for ability to smoke independently and/or to evaluate whether additional safety measures are indicated.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 20042 Based on observation, interview, and record review the facility failed to have a system in place to ensure all residents received their meal for 1 of 5 residents reviewed for nutrition and dining in the sample of 62. The findings include: On 4/22/25 at 11:57 AM, residents were sitting in the 300 dining room waiting for lunch trays. V13 Certified Nursing Assistant (CNA), and V16 CNA placed meal tickets on the table in front of the residents. The meal tickets showed the residents name and type of diet they can have. On 4/22/25 at 12:05 PM, V13 and V15 CNA were in the dining room placing bowls of soup in front of residents. On 4/22/25 at 12:12 PM, V13 and V15 were serving food to residents in the 300 hall dining room. V13 would bring a plate of food and sit it down on the table in front of the resident. Residents were being served randomly. One resident served at one table and then a resident at a different table, back and forth. Most residents were sitting at a long table in the middle of the dining room. R31 was seated on the side, at the end of the long table. Everyone at her table had been served their food and was eating. R31 did not have any food. At 12:24 PM, everyone at R31's table was eating and she still did not have any food. R31 stated, I didn't get any dinner. R31 had a meal ticket in front of her on the table that stated she has a mechanical soft diet with ground meat. At 12:26 PM, another resident (R74) at the table waved at V15 and told her that R31 did not get any food. V15 told V13 that R31 did not get any food. V13 went over to R31, picked up her ticket, and stated she has a mechanical soft diet. V13 left to get R31 food. R31 appeared upset and kept saying, I didn't get any food and I am really hungry. On 4/23/25 at 3:03 PM, V18 Activity Director stated they missed a meal at lunch yesterday and said, that's not good. V18 stated they missed giving R31 her meal. V18 stated she has seen the meal tickets on trays but did not see how they were doing it for lunch yesterday (Tuesday 4/22/25). On 4/23/25 at 3:12 PM, V4 Dietary Manager stated his staff will give the CNA's the meal tickets. The CNA will call out what they need to the server (in the kitchenette). The server will put the meal ticket on the tray and make sure what is on the card matches what the resident wants and what they can have. The tray is then taken to the resident. No resident should miss getting served. Staff know what they are supposed to do. V4 stated he is trying to find a dummy proof way to serve meals. The Face Sheet dated 4/24/25 for R31 showed diagnoses including moderate protein-calorie malnutrition, muscle weakness, hypertensive heart disease, hypothyroidism, hyperlipidemia, anxiety disorder, essential tremor, polyneuropathy, atherosclerotic heart disease, mitral valve disorder, spondylosis, and dysphagia. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The current Care Plan for R31 printed on 4/24/25 showed, Risk for fluctuating weights. R31 has the following risk factors that put her at risk for fluctuating weights. Diuretic use and heart disease. 2/16/25 - 9.1% weight loss x 1 month and 10.3% loss x 3 months. Diet: Regular. Shake, one serving three times daily. Monitor weights: Notify physician of weight changes. The Physician Order Summary dated 4/24/25 for R31 showed, Regular diet, mechanical soft with ground meat texture; Thin consistency. The facility's Serving a Meal policy (9/1/24) showed, it is the policy of this facility to serve meals that meet the nutritional needs of residents. Place tray on dining table or overbed table if resident eats in their room. Remove dome lid from tray, and check to be sure everything is included on the meal tray that is required by the diet card, and the resident's preference.

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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. 34891 Based on observation, interview, and record review the facility failed to ensure physician prescribed medications were administered as ordered for 3 of 3 residents (R29, R204, R199) reviewed for medication administration in the sample of 62. The findings include: 1. R29's face sheet printed on 4/24/25 showed diagnoses including but not limited to bilateral osteoarthritis of knee, dysphagia (difficulty swallowing), chronic pain, hypertension, spinal stenosis, left eye blindness, and benign prostatic hyperplasia. On 4/22/25 at 12:23 PM, R29 was seated in the 500-unit group dining room with a tablemate directly across from him. R29 had a medication cup next to his lunch plate and there were approximately 10 assorted colored pills inside. R29 stated he takes his noon time medications by himself at lunch time most days. There were no nurses present in the dining room. 2. R204's face sheet printed on 4/24/25 showed diagnoses including but not limited to rhabdomyolysis (breakdown of muscle tissue), hypothyroidism, hyperkalemia, dementia with anxiety, heart failure, chronic kidney disease, and hypertension. On 4/22/25 at 11:33 AM, R204 was seated in his room talking with a visitor friend. A medication cup of an unidentifiable orange fluid was on his bedside table. R204 said it was his blood pressure medication and I just haven't felt like taking it yet. R204 said the nurse just leaves it with him in the room. 3. R199's face sheet printed on 4/24/25 showed diagnoses including but not limited to acute cystitis, dementia, diabetes mellitus, cerebral infarction, embolism and thrombosis of arteries, abnormal blood chemistry findings, and kidney transplant status. On 4/23/25 at 10:28 AM, R199 was seated in her wheelchair and alone in her room. A tube of a topical arthritis pain cream was on her bedside table. V22 (Licensed Practical Nurse) entered the room and said, Oh, she is not supposed to have this with her. It should be kept in the medication cart. 4. On 4/22/25 at 12:35 PM, an unidentifiable white, round pill was laying on the counter of the 500-unit group dining room. The pill was directly next to a resident dining table and easily within reach. V3 (Assistant Director of Nurses) was questioned about the pill and stated it was acetaminophen 325 milligrams. V3 said she had no idea why it would be lost in the resident dining room. On 4/24/25 at 9:36 AM, V10 (Registered Nurse) said there are no residents on the 500 unit that can self-administer their pills. All residents need to be watched to ensure they take them, don't choke, or lose them. Nurses should not be leaving any medications with the residents. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/25 at 10:50 AM, V2 (Director of Nurses) stated all residents need to be assessed prior to being left with medications. The care plan should reflect it as well. The assessment shows the resident is cognitively intact and able to understand when and how to properly take the medication. It is important to ensure resident safety. V2 said nurses should be staying with the resident until all medications are swallowed. V2 reviewed the electronic charts for R29, R204, and R199. V2 was unable to locate any assessments or care plans related to the ability to self-administer medications. The facility's Resident Self-Administration of Medication policy dated 9/1/24 states: It is the policy of this facility to support each resident's right to self-administer medication. A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45395 Based on observation, interview, and record review, the facility failed to adequately store food items by not properly labeling and/or dating items. This failure has the potential to affect all 102 residents who currently reside in the facility. Findings include: On 04/22/2025, upon entering facility, V1 (Administrator) indicated census of 102 in-house. Facility provided a completed CMS 802 form that indicated in-house resident census of 102. On 04/22/2025 at 10:32 AM, surveyor conducted initial kitchen tour with V4 (Dietary Manager) with the following observations. At 10:34 AM, upon entering walk in freezer #1, observed on an upper shelf to the left of freezer door, an undated and opened clear plastic bag with mixed vegetables that was halfway filled with vegetables, and an undated cardboard box which contained an inner clear plastic bag that was opened and visibly sticking out from the top of box. This box was half filled with frozen hot dogs that were not properly sealed with frost visible to several of the hotdogs within the bag. Also observed a 3 gallon sized, brown tub of chocolate ice cream that was less than half filled, undated, lid not properly closed, and with visible ice crystals covering majority of the ice cream. V4 (Dietary Manager) said someone was being lazy then said that all food items should be properly dated and sealed to maintain its quality and to avoid freezer burn. On 04/22/2025 at 10:43 AM, observed on a shelf near the back wall of the dry storage room, an undated and opened box which contained an inner clear plastic bag that was opened and visibly sticking out from the top of box that was half filled with parboiled rice. Per V4 (Dietary Manager), all food items should be properly dated and sealed to ensure no pests or contaminants get inside. On 04/22/2025 at 10:45 AM, observed a female dietary aide walking through the kitchen wearing a hair net with a long ponytail hanging down to her midback area and not within the hair net. V4 (Dietary Manager) said her all hair should be always within the hairnet for sanitation purposes. On 04/22/2025 at 10:48 AM, V4 (Dietary Manager) placed a sanitizer test strip into a red sanitation bucket that was near the dish machine for approximately 10 seconds. V4 then removed the test strip which stayed the same color (brownish-orange colored). V4 said the strip should turn to a green color that indicates the sanitizer concentration level is between 200 and 400 parts per million (PPM). V4 then said, they must have added soap to the bucket and not sanitizer. V4 (Dietary Manager) added that the concentration levels should be within the appropriate range to prevent the growth of bacteria. On 04/23/2025, V4 (Dietary Manager) provided an in-service training dated 04/22/2025 regarding all items in the refrigerator and freezer being properly stored and dated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Food Safety Requirements policy last revised 10/23/2024 reads in part: it is the policy of this facility to procure food from sources approved or considered satisfactory by federal, state and local authorities. Food will also be stored, prepared, distributed and served in accordance with professional standards for food service safety .1. Food safety practices shall be followed throughout the facility's entire food handling process. This process begins when food is received from the vendor and ends with delivery of the food to the resident. Elements of the process include the following .storage of food in a manner that helps prevent deterioration or contamination of the food, including from growth of microorganisms .7. staff shall adhere to safe hygienic practices to prevent contamination of foods from hands or physical objects .dietary staff must wear hair restraints to prevent hair from contacting food . Labeling and Dating Foods policy last revised 2017 reads in part: to decrease the risk of food borne illness and to provide the highest quality, foods is labeled with the date received, the date opened and the date by which the item should be discarded. Storage of Dry Goods/Foods policy last revised 2017 reads in part: opened products are labeled, dated with the use by date and tightly covered to protect against contamination from insects and rodents. Opened products that have not been properly sealed and dated are discarded. Refrigerated Food policy last revised 2017 reads in part: refrigerated potentially hazardous food (PHF) or time/temperature controlled for safety (TCS) foods are labeled with the date received and if not opened, are discarded by the manufacturer's expiration date. If opened, the cold food item is labeled with the date opened and the date by which to discard or use by.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20042 Based on observation, interview, and record review the facility failed to ensure staff wore personal protective equipment when providing care for residents on enhance barrier precautions (EBP) and carrying soiled linen from a room for 3 of 3 residents (R47, R23, & R203) on transmission based precautions in the sample of 62. The findings include: 1. On 4/22/25 at 10:54 AM, there was an enhanced barrier precaution (EBP) sign under R47's name and next the doorway of her room. There was a three drawer container sitting on the floor next to R47's doorway to her room. R47 was in bed laying on her left side and had a bandage to her right elbow. R47 had oxygen on at 2 liters via nasal canula. V13 Certified Nursing Assistant (CNA) had a mask on and no other personal protective equipment (PPE). V13 and came into R47's room to check her feet to see if they were offloaded. V13 pulled back the residents blankets and the resident had an offloading boot in place to her right foot/heel. V13 removed the boot and R47 had a gauze dressing to her right foot and heel. V13 put the heel boot back on R47. R47's left leg was contracted at the knee and she was laying on her left side. R47 had a dressing to her left foot but did not have an offloading boot in place. V13 walked over to R47's night stand and picked up the offloading boot. R47 placed the boot on R47's bed. R47 applied the offloading boot to R47's left foot. V13 was shown the EBP sign next to the residents door that was above the PPE container. V13 stated stated that sign was not for R47. V13 stated R47 was moved from room [ROOM NUMBER] to 307 and the sign was just left up. V13 stated that no one gave any precautions for the resident. On 4/22/25 at 11:18 AM, V14 Licensed Practical Nurse (LPN) stated R47 she would check in computer to see why R47 has EBP, and if she has wounds. V14 stated R47 has wounds to her left big toe, right big toe, right hip, medial side of left lower extremity, sacrum, right lateral back, and left fifth toe. V14 stated staff should wear gloves and a gown with close contact to R47. On 4/23/25 at 10:47 AM, V3 Assistant Director of Nursing (ADON) brought in a list of residents on EBP that was dated dated 4/23/24 for Enhanced Barrier Precautions. The form showed R47 was on EBP for a sacral pressure ulcer. R47's current Care Plan printed 4/24/25 for R47 showed R47 is on EBP due to the presence of a sacral wound with an initiation date of 8/28/24. Ensure that gown and gloves are used during high-contact resident care activities (like dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, assisting with toileting, and wound care for any skin opening requiring a dressing) that provide opportunities for transfer of multidrug resistant organisms to staff hands and clothing. The Physician Order Review Report dated 4/24/25 for R47 showed wound treatments to a left fifth toe deep tissue injury, unstageable right lateral back wound, left great toe wound, left lower medial leg wound, sacral wound and right hip wound. Enhanced Barrier precautions due to presence of sacral wound. (continued on next page)

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	04/24/2025

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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Face Sheet dated 4/24/25 for R47 showed diagnoses including rheumatoid arthritis, pressure ulcer, chronic obstructive pulmonary disease, anemia, congestive heart failure, and muscle weakness. 2. On 4/22/25 at 1:53 PM, there was an EBP sign next to the doorway of R23's room. R23 was on toilet in bathroom. V16 CNA answered R23's call light. V16 did not have a gown on. V16 used the sit to stand lift to stand R23 up from the toilet, provided peri-care, and pulled her incontinence brief up, removed his gloves, and pulled her pants up. V16 transferred R23 to her wheelchair. V16 was asked why there an EBP sign outside the residents door. V16 stated it might be for R23 because of her legs. V16 stated he was not 100% sure what was going on with R23's legs but the wound nurse comes and wraps them. The Wound Summary for R23 dated 4/22/25 showed a full thickness wound to the lateral side and back of her right leg; full thickness wound of right inner ankle, and full thickness wound to her lateral left lower extremity. On 4/23/25 at 10:47 AM, V3 Assistant Director of Nursing (ADON) brought in a list of residents on EBP that was dated 4/23/24 for Enhanced Barrier Precautions. The form showed R23 was on EBP for a wound to her right malleolus. The Face Sheet dated 4/24/25 for R23 showed diagnoses including varicose veins of left lower extremity with both ulcer of the other part of lower extremity and inflammation, peripheral vascular disease, type 2 diabetes mellitus, hypothyroidism, hyperlipidemia, hypertension, congestive heart failure, and peripheral vascular disease. The Physician Order Review Report dated 4/24/25 for R23 showed, enhanced barrier precaution related to presence of wound. The current Care Plan for R23 printed on 4/24/25 showed, R23 is on enhanced barrier precaution due to presence of wounds. Ensure that gown and gloves are used during high-contact resident care activities(like dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, assisting with toileting, device care for those with central line, urinary catheter, feeding tube, tracheostomy/ventilator, and wound care for any skin opening requiring a dressing) that provide opportunities for transfer of MDROs to staff hands and clothing. 34891 3. R203's face sheet printed on 4/24/25 showed an admitted [DATE]. R203's initial wound consultation report dated 4/21/25 showed a stage 4 pressure injury to the sacral. R203's April 2025 order summary report showed an order start dated on 4/22/25 for enhanced barrier precautions due to the presence of the sacral wound. The same report showed an order start dated 4/20/25 for metronidazole (antibiotic) 500 milligram tablet to be given daily for three times for antimicrobial infection. The report showed metronidazole external cream (antibiotic) to be applied to the sacrum every day and evening shift for antimicrobials. (continued on next page)

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	04/24/2025

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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/25 at 9:42 AM, R203 was lying in bed. A sign was posted outside her room showing she was on Enhance Barrier Precautions. The sign showed gowns and gloves must be worn during direct resident care including when changing linens, changing briefs, and when skin openings were present. At 9:48 AM, V11 and V12 (CNAs-Certified Nurse Aides) donned gloves only and changed R203's incontinence brief. R203 was rolled from side to side and the CNAs stated her sheet was wet from her sweating. The bed sheet was changed and the new brief was put on. V11 and V12 did not don gowns during the care. V12 grabbed the dirty bed linens and held them against her body while she carried them down the hallway to the dirty linen room. Along the way, V12 accidentally dropped a sheet on the floor in front of the nurses station. V11 and V12 were questioned regarding the enhanced barrier precaution sign. V11 said R203 has open wounds and that means gowns and gloves are needed when caring for her. V11 said, she guessed they just missed it. V11 said dirty linens should be put in a bag if contaminated with blood or bodily fluids and sweat is considered a bodily fluid. V12 said she did not use a bag for the linens because she did not have one. The housekeeping staff did not leave any bags in the room. On 4/24/25 at 11:49 AM, V3 (Assistant Director of Nurses/Infection Control Preventionist) stated enhanced barrier precautions are used to be more cautious and stop any exposure to infections. Staff need to wear gowns and gloves during resident care. Wounds and infections are a definite reason staff need extra PPE. The signs are posted outside of the room to show they need to wear it. We just did a training on this in February and all staff should know the protocol at this point. V3 said dirty linens need to be put in bags before being carried out of the room. The bags keep any soiling or germs away from other surfaces. Every resident room is restocked daily and as needed. There is no reason a room should not have the bags available to the CNAs. R203's care plan showed a focus area related to enhanced barrier precautions in use. Interventions included: Ensure that gown and gloves are used during high-contact resident care activities (like .providing hygiene, changing linens, changing briefs .device care or use for those with .any skin opening requiring a dressing) that provide opportunities for transfer of MDROs (germs) to staff hands and clothing. The facility's Handling Soiled Linen policy dated 9/1/24 states: 3. Linen should not be allowed to touch the uniform or floor and should be handled as little as possible, with minimum agitation to avoid contamination of air, surfaces, and persons. 4. Used or soiled linen shall be collected at the bedside and placed in a linen bag or designated lined receptacle. When the task is complete, the bag shall be closed securely and placed in the soiled utility room.