

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/02/2025
NAME OF PROVIDER OR SUPPLIER  Serenity Estates at Morris		STREET ADDRESS, CITY, STATE, ZIP CODE  1223 Edgewater Morris, IL 60450	

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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31849</p> <p>Based on interview and record review, the facility failed to ensure medications were readily available to newly admitted residents.</p> <p>This applies to 2 of 3 residents (R1, R2) reviewed for medications in the sample of 3.</p> <p>The findings include:</p> <p>1. R1's Face Sheet showed he was admitted to the facility on [DATE]. R1's 4/24/25 Minimum Data Set (MDS) showed he is cognitively intact.</p> <p>R1's Face Sheet showed his diagnoses include COPD (chronic obstructive pulmonary disease) with acute exacerbation, depression, emphysema, chronic respiratory failure, asthma, sciatica, hyperlipidemia, and a rib fracture.</p> <p>On 4/29/25 at 12:50 PM, R1 stated he waited a long time to get all of his medications after he was admitted .</p> <p>On 4/28/25 at 5:35PM, V3, LPN (Licensed Practical Nurse), stated she worked on 4/19/2025, and worked a double shift. V3 stated she assisted with R1's admission, but she was not his assigned nurse. V3 stated the cut-off time for the pharmacy ordering is between 4:00-5:00 PM for medications to be filled, but some medications are available in the facility's (medication storage). V3 stated it is a case-by-case scenario if a STAT delivery is needed. V3 stated she would take everything that was needed and available from the (medication storage) and then call the pharmacy for a STAT delivery. V3 stated a STAT delivery is supposed to deliver within three hours. V3 stated R1 came to the facility on [DATE], after 4:00 PM and he was assigned to V4 (LPN).</p> <p>On 4/29/25 at 11:51AM, V4 (LPN) stated she was assigned to R1 and R2 on 4/19/25, and she has worked at the facility for only three weeks. V4 stated she had 30 residents and two admissions on 4/19/25 and it was difficult. V4 stated she did not have access to the (medication storage), and was not aware that she could call the pharmacy to gain access.</p> <p>On 4/29/25 at 9:28AM, V5 (Pharmacist) stated deliveries are twice a day, around 8:00 AM and 4:00 PM. V5 stated if they get the orders after the cut off time, the meds will go to the following delivery.</p> <p>(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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's Discharge paper from the hospital showed he was discharged at 4:01 PM from the hospital. R1's 4/19/25 discharge orders for his scheduled doses of atorvastatin and montelukast showed next dose: today (4/19/25) at bedtime. R1's April 2025 MAR (Medication Administration Record) showed his 4/19/25 doses of atorvastatin and montelukast scheduled at 8:00 PM simply had an X.</p> <p>R1's 4/19/25 discharge orders for five other medications (meloxicam, pantoprazole, sertraline, tamsulosin and an Incruse inhaler) showed next dose: tomorrow (4/20/2025) morning.</p> <p>R1's April 2025 MAR showed a 5 or a 9 for his 6:00 AM pantoprazole ad sertraline doses and his 8:00 AM doses of his Incruse inhaler, meloxicam, tamsulosin, Symbicort inhaler, and his buprenorphine/naloxone. Per the legend on the MAR, a checkmark indicates a medication was administered, and a 5 or 9 is a referral to a progress note. R1's 4/20/25 MAR progress notes from 8:53 AM showed meds not delivered yet, on way and 9:22 AM showed .will call pharm to see when delivery of narcotics and any missing meds . Notes from 11:57 for R1's Symbicort inhaler showed not available; at 12:04 PM for meloxicam n/a; 12:06 PM for pantoprazole n/a; and 3:51 PM for sertraline not done.</p> <p>The pharmacy medication delivery sign-in sheet showed R1's medications were delivered on 4/20/2025 at 2:26 PM, and were received by V4, LPN.</p> <p>2. R2's Face Sheet showed she was admitted to the facility on [DATE]. R2's MDS showed she was cognitively intact.</p> <p>R2's Face Sheet showed her diagnoses include diabetes, peripheral vascular disease, congestive heart failure, stage 4 kidney disease, cerebral infarction, transient ischemic attacks, and pulmonary hypertension.</p> <p>On 4/28/25 at 12:45PM, V7 (R2's family) stated when she asked about R2's medications on Sunday 4/20/25, staff told her R2's medications were discontinued until Monday (4/21), and R2 did not get her medications. V7 stated R2 had been living in an Assisted Living and they had called her because they got a fax about R2's medication and she was no longer there. V7 stated she went to the Assisted Living and got all R2's medications to bring to the skilled care. V7 stated around 4:00 PM on Monday, she was told R2's medication arrived from the pharmacy, and the facility no longer needed the medications from the Assisted Living.</p> <p>On 4/28/25 at 1:37 PM, V8, RN (Registered Nurse), stated as soon a new admission comes in, staff look at the medication list that come from the hospital with the discharge instructions. V8 stated nurses enter the medications one at a time into the computer in the physician orders, then then pharmacy takes over.</p> <p>R2's hospital discharge orders from 4/19/25 showed she was to receive clopidogrel and Lasix next dose: today (4/19/25) evening, her Humalog insulin next dose: today (4/19/25) evening with meal, and her hydralazine next dose: today (4/19/25) at bedtime. The discharge orders also showed R2 was to receive six other medications (famotidine, fluoxetine, Farxiga, losartan, metolazone, and prednisone) next dose: tomorrow (4/20/25) morning, and levothyroxine next dose: tomorrow (4/20/25) morning before meal.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R2's progress notes showed her medication orders were not entered in the computer until 4/20/25, starting at 6:39 PM, on Sunday. R2's Physician Order Sheet showed the orders were put in on the 4/20/25, and medications were to start being administered on Monday, 4/21/25. The pharmacy medication delivery manifest showed ten of R2's medications were delivered on Monday 4/21/25, and signed for by facility staff at 3:33 PM. R2's April MAR showed she missed twelve doses of various oral medications, three scheduled doses of insulin, and potentially five doses of sliding scale insulin.</p> <p>R2's progress note from 4/20/25 at 9:49 PM showed, Patient was admitted to (facility) at [4 PM] on 4/19/25.</p> <p>On 4/29/25 at 2:38 PM, V1 (Administrator) verified there was no documentation showing the physicians were notified about the medication administration delays.</p> <p>The facility's March 2023 Pharmacy Hours and Delivery Schedule policy showed, New orders and refill requests may be faxed or sent electronically at any time Facility-specific fax cut-off times are arranged between the facility and pharmacy New orders communicated to the [name] pharmacy after the cut-off time will automatically go into the next regular delivery for the facility . If .the resident is in need of medication as a STAT order, the medication should be started from the emergency dispensing kit if applicable, and/or an emergency delivery must be requested An emergency delivery can be requested by sending the order to the [name] pharmacy, contact the pharmacy by phone to alert them that you sent a STAT order .</p> <p>The facility's Unavailable Medications policy (implemented 8/1/24) showed, .4. Staff shall take immediate action when it is known that the medication is unavailable determine what efforts have been attempted by the facility or pharmacy provider to obtain the medication Notify Physician of inability to obtain medication medication .obtain alternative treatment orders and/or specific orders for monitoring . 5. Staff shall follow procedures for medication errors, including physician/family notification .</p>		