STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146077	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Serenity Estates at Morris	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)
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 provide a residents POA (Power of Attorney) notification of end of therapy services. This applies to 1 of 1 resident (R6) reviewed for notification of end of therapy. The findings include: R6 was admitted to the facility on [DATE] with multiple diagnoses which included hemiplegia and hemiparesis, muscle disorders, difficulty in walking, cognitive communication deficit, diabetes, Alzheimer's Disease, unspecified visual disturbance, depression, hearing loss, and dementia per the Face Sheet. On 04/08/26 at 9:30 AM, R6 stated her daughter is her POA. R6 stated she used to be in therapy and does not know why it ended. R6 stated she did not remember receiving or signing a letter stating therapy would be ending. R6 stated if the facility had given her a letter stating that therapy was ending, she would have given it to her daughter. R6 stated she makes decisions with her daughter. On 04/07/26 at 1:00M, V11 (Social Services Director) stated she issued a NOMNC (Notice of Medicare Non-Coverage) to R6 when her skilled therapy ended in December 2025 by her. V11 stated a NOMNC was not issued to R6 when her Part B therapy ended in March 2026. V11 stated she did not send a NOMNC to R6's POA to notify her of therapy ending. V11 stated she did not take into consideration that R6 had a diagnosis of Alzheimer's Disease.R6's EMR (Electronic Medical Record) showed a signed NOMNC by R6 on 12/16/25. The EMR showed no notification of R6's POA being notified of the last covered day of skilled services. The EMR showed no documentation of a NOMNC being given to R6 or R6's POA for the end of therapy, last covered dates 03/06/26 and 02/24/26. The facility was unable to show that R6's POA had been notified of either end of therapy services. My Power of Attorney for Health Care dated 09/16/16 showed R6's daughter (Name) as the POA. The form showed R6's initials next to a box stating, I Authorize My Agent to make decisions for me starting now and continuing after I am no longer able to make them for myself. While I am still able to make my own decisions, I can still do so if I want to. R6's Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage dated 12/16/25 was signed by R6. The notice showed Medicare does not pay for everything, even some care that you or your health care provider think you need. The Skilled Nursing Facility (SNF) or its Utilization Review Committee believes that the care listed below does not meet Medicare coverage requirements. Beginning on 12/19/25, you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs. The care(s) you have been receiving during the Inpatient Skilled Nursing Facility stay includes Physical Therapy and Occupational Therapy. The Notice of Medicare Non-coverage form dated 12/16/25 and signed by R6 showed, Medicare coverage of your current skilled nursing services will end on 12/18/25. R6's Impaired cognitive function/dementia or impaired thought process r/t Alzheimer/dementia care plan dated 12/03/25 showed interventions: monitor/document/report to MD any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficult understanding others. Impaired cognitive function r/t Alzheimer's, impaired decision-making, short-term memory loss care plan dated 01/04/26 showed communicate with the resident/family/caregivers regarding residents capabilities and needs.The facility was unable to (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provide a NOMNC for the end of Part B therapy in March 2026.The facility's Advance Beneficiary Notices Policy dated 10/21/25 showed, A Notice of Medicare Non-Coverage (NOMNC), Form CMS-10123, shall be issued to the resident/representative when Medicare covered service(s) are ending, no matter if resident is leaving the facility or remaining in the facility. Delivery requirements: The notice shall be written legibly in a language and/or format that the resident/representative understands. The current CMS-approved version of the forms shall be used at the time of issuance to the beneficiary (resident or resident representative). For part A items and services, the facility shall use the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN). For Part B items and services, the facility shall use the Advance Beneficiary Notice of Non-Coverage (ABN).

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect residents right to privacy and confidentiality. This applies to 2 of 2 residents (R7 and R8) reviewed for resident's rights. The findings include:1. R7 was admitted to the facility on [DATE] with multiple diagnoses which included central cord syndrome of cervical spinal cord, congestive heart failure, quadriplegia, anxiety, major depressive disorder, and benign prostatic hyperplasia per the admission Record. On [DATE] at 9:15 AM, the surveyor and V1 (Administrator) viewed a 53 second video posted on V28's (CNA/Certified Nursing Assistant) Tik Tok social media account. The video showed R7 wearing a gown and being lifted by a mechanical lift. R7 was seen on the video in the washroom, clothed, performing personal hygiene activities. R7 was seen on another occasion in his room, sitting in a wheelchair, and organizing his personal items on the bedside table. On another day, R7 was sitting in the wheelchair, catching and throwing a ball. R7 and R8 were seen trying to grab a ball with a reach extender device. Another clip in the video showed a resident, wearing a gown, with his left arm across the right arm, holding a rosary and a death notice with a picture of a female. The last clip of the video showed an In Loving Memory card with R7's date of birth , date of death , and the name of the funeral home. The end of the video showed the name of the social media site, along with V28's (CNA) username for the site. On [DATE] at 10:00 AM, V1 identified the two residents seen in the social media video as R7 and R8. V1 stated V28 was employed at the facility until [DATE]. V1 stated R7 was a long-time resident of the facility until he died, and R8 was still a resident in the facility. V1 stated posting residents on social media is a violation of their policy, resident's rights, and it is the facility's responsibility to protect the residents. V1 stated the facility did not have permission from R7 or the family to take videos, pictures, or post on social media. On [DATE] at 10:45 AM, V2 (DON/Director of Nursing) stated it was wrong for V28 to share videos of residents and it should not have happened. V2 stated V28 violated the facility's social media policy and HIPAA (Health Insurance Portability and Accountability Act). V2 stated her expectations for the staff are no videos or pictures of residents.On [DATE] at 11:15 AM, V27 (Activity Director) stated she obtains consents from the families or residents for videos and pictures to be taken of the residents. V27 stated she had never obtained any written consents from R7 and R8, or their families for pictures and videos to be taken of them. V27 stated the employees are not allowed to post residents on their personal social media. On [DATE] at 2:49 PM, V28 stated she worked at the facility for almost two years. V28 stated she resigned on [DATE] and her last day of employment at the facility was [DATE]. V28 stated she posted a collage of videos of R7 on her social media account on [DATE] and deleted it on [DATE]. V28 stated she knew it was not right to post R7 on her social media account. V28 stated she did not have permission or written consent to take pictures, video recordings, or post on social media. V28 verified that her username on Tik Tok was the same as the username at the end of the posted video. R7's Census List showed R7 was admitted to the facility on [DATE] and expired on [DATE]. R7's Progress Notes dated [DATE] at 6:33 AM, showed Patient is now on hospice care. Patient is in the bed resting comfortably. Will continue to monitor. Progress Notes dated [DATE] at 11:18 AM, showed POA (Power of Attorney) in room with patient. Patient ending near of life and having pain and terminal agitation. Progress Notes dated [DATE] at 10:30 PM, showed Resident expired at 6:45 PM. Resident on hospice. Picked up by (Funeral Home) at 9:30 PM, on [DATE].R7's Audio, Video and Photographic Release Form was signed by R7's POA. The form stated Please do not use my name or photograph within the facility in the following circumstances. Please do not release my name or photograph outside the facility without my specific written authorization.2. R8 was admitted to the facility on [DATE] with multiple diagnoses which included hemiplegia and hemiparesis, major depressive disorder, anxiety, hypertensive chronic kidney disease, aphasia, and dysphasia. R8's EMR (Electronic Medical Record) contained no written consents for R8 to be photographed, video recorded, or to be on any employees social media site. The facility was unable to (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provide written consent for audio, video, and photographic. The facility's Social Media Use Policy, revised [DATE], showed Policy: It is the policy of this facility to protect residents, staff, visitors, volunteers and practitioners against misuse of social media content. Taking, keeping, or distributing unauthorized photographs or audio/video recordings of residents through multimedia messages or on social media networks is a violation of the resident's right to privacy and confidentiality. Staff members must recognize that they have an ethical and legal obligation to maintain resident privacy and confidentiality at all times. Policy Explanation and Compliance Guidelines: 1. Employees are strictly prohibited from transmitting by way of any electronic media any resident-related image or information that may be reasonably anticipated to violate resident rights to confidentiality or privacy. This includes information that could degrade or embarrass the resident. 2. Photographs or recordings of a resident and or his or her private space without the resident or designated representative's written consent, is prohibited. Examples include taking unauthorized photographs/videos of: d. taking unauthorized photographs or recordings of residents in any state of dress or undress using any type of equipment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a care plan conference for a resident and their representative. This applies to 1 of 1 resident (R6) reviewed for care planning. The findings include: R6 was admitted to the facility on [DATE] with multiple diagnoses which included hemiplegia and hemiparesis, muscle disorders, difficulty in walking, cognitive communication deficit, diabetes, Alzheimer's Disease, unspecified visual disturbance, depression, hearing loss, and dementia per the Face Sheet. On 04/08/26 at 9:30 AM, R6 stated neither she nor her POA had attended a care plan meeting since being admitted to the facility. On 04/07/26 at 1:00 PM, V11 (Social [NAME] Director) stated care plan conferences have not been done as they should have been. Stated if a care plan conference had been done for R6, she would have documented the progress notes. V11 stated she was unable to provide documentation of the care plan conference being conducted. On 04/09/26 at 2:55 PM, V1 (Administrator) stated she was not able to find a documented record of a care plan conference being held for R6. V1 stated care plan conferences should be held for residents at a minimal of every 90 days or with significant change. V1 stated if conferences are not conducted, it could result in a communication breakdown between the resident, family, and facility.R6's EMR (Electronic Medical Record) showed no evidence of a care plan conference being conducted. The facility was unable to provide documentation that a care plan conference with R6 or R6's POA (Power of Attorney) had been conducted. The facility's Comprehensive Care Plans Policy dated 10/21/25, showed It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. The comprehensive care plan will be prepared by an interdisciplinary team, that includes but is not limited to the resident and the resident's representative, to the extent practicable.