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	05/02/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to have enough full body lifts to accommodate residents' needs. This applies to 2 of 2 residents (R1 and R3) reviewed for mechanical lifts. The findings include: 1. On 04/30/26 at 1:00 PM, the surveyor and the administrator toured the facility; one electric full body mechanical lift was on the first floor in use. One manual lift was on the second floor in use. No other full body lifts were seen throughout the facility.On 04/30/26 at 10:40 AM, R1 was sitting in a wheelchair in the room. R1 stated the facility has only one working full body mechanical lift in the facility. R1 stated when she is ready to get out of bed or go back to bed, there is not a mechanical lift available. R1 stated she has to stay in bed or in her wheelchair for extended times. R1 was admitted to the facility on [DATE] with multiple diagnoses which included hemiplegia and hemiparesis affecting left non dominant side, cerebral infarction, diabetes, osteoarthritis, muscle weakness, cognitive communication deficit, and need for assistance with personal care per the admission Record. R1's MDS (Minimum Data Set) dated 03/20/26 showed R1 was cognitively intact. R1 required the use of a wheelchair and was dependent upon staff for transferring. R1's ADL (Activities of Daily Living) self-care performance deficit showed, Transfer: Full body lift machine and two assist.2. On 04/30/26 at 8:45 AM, R3 was sitting in a wheelchair in the room. R3 stated she is transferred via full body mechanical lift. R3 stated there is only one full body mechanical lift in the facility. R3 stated a few days ago, the CNA's (Certified Nursing Assistant) told her she could not lay down because there was no mechanical lift available. R3 stated she likes to eat her lunch while sitting in the wheelchair but prefers to eat dinner in bed. R3 stated she had to eat dinner while sitting in the wheelchair. R3 stated she sat in the wheelchair for six hours that day. R3 stated multiple CNA's told her they were doing the best they could with getting her in bed. On 04/30/26 at 9:43 AM, V4 (CNA) stated the entire facility has two full body mechanical lifts, one electric and one manual. V4 stated both of the lifts were on another unit. V4 stated there are times when the residents cannot get out of bed or lay down because they do not have lifts available at that time.On 04/30/26 at 10:20 AM, V6 (CNA) stated on 04/27/26 or 04/28/26, the facility was down to one full body mechanical lift. V6 stated it delays care when there are not enough mechanical lifts. V6 stated R1 asked to lay down. V6 stated R1 was informed that the lift was upstairs and that it might be a while before she could lay down. V6 stated she was not able to put R1 in bed by the end of her shift, and she reported it to second shift. On 04/30/26 at 12:30 PM, V8 (CNA) stated on 04/28/26, R1 had her call light on and wanted to go back to bed. V8 stated she had a hard time finding a mechanical lift to put R1 back in the bed. V8 stated she checked a few units and did not find the lift. V8 stated she went to another unit, and the lift was charging. V8 stated when the lift is charging, they cannot use it. V8 stated it was endorsed to the next shift that R1 wanted to go to bed. On 05/02/26 at 1:15 PM, V1 (Administrator) stated one of the lifts was in the maintenance office due to safety concerns. V1 stated all units, first and second floor are sharing the full body mechanical lifts right now. V1 stated it is expected that residents needs are met timely, and they should be able to lay down as soon as they ask. R3 was admitted to the facility on [DATE] with multiple diagnoses which included polyneuropathy, megaloblastic anemias, diabetes, major depressive disorder, hypertension, osteoarthritis, (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	intervertebral disc degeneration per the admission Record. R3's MDS dated [DATE] showed R3's cognition was intact. The same MDS showed R3 was dependent upon staff for transfers.The facility's Safe Resident handling/Transfers Policy, revised 10/01/25, showed 14) Resident lifting and transferring will be performed according to the resident's individual plan of care.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 administer prescribed medications as ordered. This applies to 1 of 1 resident (R1) reviewed for medications. The findings include: R1 was admitted to the facility on [DATE] with multiple diagnoses which included hemiplegia and hemiparesis affecting left non dominant side, cerebral infarction, diabetes, osteoarthritis, muscle weakness, cognitive communication deficit, and need for assistance with personal care per the admission Record. R1's Order Summary for April 2026, showed an active order for Alprazolam (Xanax) 0.25 mg (milligrams) at bedtime. R1's MAR (Medication Administration Record) for 04/01/26-04/30/26 showed Alprazolam 0.25 mg at bedtime a scheduled medication. The same MAR showed for the dates of 04/11/26, 04/12/26, and 04/13/26, there was a code with the number 11 in those boxes along with the administering nurse initials. The MAR's Chart Codes showed that the number 11 code meant Med not available.On 05/01/26 at 10:15 AM, V13 (Psych Nurse Practitioner) stated the pharmacy informed her that the nurses could get Xanax from the convenience box/emergency medications until her shipment arrives to the facility. On 05/01/26 at 2:45 PM, V10 (RN/Registered Nurse) stated on 04/11/26 she signed on R1's MAR (Medication Administration Record) that the Xanax was not available. V10 stated she did not call the doctor, nurse practitioner, or the pharmacy to inform them that R1 did not have the medication available. V10 stated the nurses are supposed to call the doctor and inform them if a resident did not receive a medication. On 05/02/26 at 3:29 PM, V11 (RN) stated on 04/12/26 she signed on R1's MAR that the Xanax was not available. V11 stated she did not call the pharmacy to see what was going on with the medication. V11 stated she should have called the doctor to let them know that R1 had not received Xanax, and if they wanted to do something else. V11 stated she did not try to get the Xanax from the emergency supply of medications at the facility. On 05/02/26 at 3:00 PM, V2 (DON/Director of Nursing) stated she was unaware that R1 had missed three doses of Xanax. V2 stated the nurses had not called her to inform her of the medication not being in the facility. V2 stated the nurses are aware if medications are not available, they could get it from the Nexus (emergency stock). V2 stated R1 should not have missed three doses of Xanax, the pharmacy and the providers should have been called. V2 stated benzodiazepines should not be stopped abruptly, withdrawal symptoms or worse could occur.The facility's Medication Administration Policy, revised 10/01/25, showed Policy Explanation and Compliance Guidelines: 12) b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. 23) Correct any discrepancies and report to nurse manager.