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	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Serenity Estates at Morris	1223 Edgewater Morris, IL 60450

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review, the facility failed to provide safe medication storage and labelling practices for residents receiving prescription and narcotic medications.This applies to 4 residents (R1, R5, R12, and R105) sampled for medication storage and labeling in a sample of 26.The findings includes:1. According to the face sheet, R1 was admitted to the facility on [DATE], and had multiple diagnoses including (COPD) chronic obstructive pulmonary disease with acute exacerbation, acute kidney failure, and hypertensive heart disease with heart failure.R1's POS (Physician Order Sheet), dated November 14, 2025, showed an active order for Trelegy Ellipta Inhalation Aerosol Powder Breath Activated inhaler to be administered one time a day for COPD.On December 16, 2025, at 9:25 AM, V19 (Nurse) administered Trelegy Ellipta Inhalation Aerosol Powder Breath Activated inhaler, which had no pharmacy label, to R1. V19 said the medication was probably brought by R1 when admitted to the facility. V19 also said R1 had an unopened Trelegy Ellipta Inhalation Aerosol Powder Breath Activated inhaler sent by the facility pharmacy which had a label, but the nurses have been administering the inhaler without the pharmacy label to R1.On December 17, 2025, at 10:21 AM, V2 (Director of Nursing/DON) said the unlabeled Trelegy Ellipta Inhalation Aerosol Powder Breath Activated inhaler medication the facility nurses had been administering to R1 was brought with R1 from another hospital upon admission. V2 also said it was not safe to administer medications that do not have the facility's pharmacy labelling on the packet to residents. V2 also added that the facility's pharmacy does not send medications without labeling for the residents, and the facility should have sent the medication home with R1's family. In addition, V2 said the medication should not have been administered to R1 to ensure the resident is receiving the correct medications sent by the pharmacy.2.On December 17, 2025, at 10:20 AM, a narcotic medication card containing 30 tablets of Dipen/Atrop tablet 2.5 (MG) milligrams belonging to R105 was in the facility's locked narcotic medication box. The narcotic medication card showed that two medications (pocket 10 and 20) were opened and re-taped with a paper tape. V21 (Nurse) said the medication has had the tape on the medication card for a long time, although nurses are supposed to discard opened and unused narcotic medications with two nurses.3. On December 17, 2025, at 10:38 AM, a narcotic medication card containing 22 tablets of tramadol HCL 50 MG belonging to R12 was in the facility's locked narcotic medication box. The narcotic medication card showed that two medications (pocket 20 and 27) were opened and re-taped with a paper tape. V20 (Nurse) said nurses are supposed to discard opened and unused narcotic medications with two nurses and should not them to the narcotic card.4. On December 17, 2025, at 11:57 AM, during medication cart check with V19 (Nurse), a narcotic medication card containing 15 tablets of Alprazolam tablet 0.5 MG belonging to R5 was in the facility's locked narcotic medication box. The narcotic medication card showed that one medication (pocket 1) was opened and re-taped with a paper tape. On December 17, 2025, at 3:07 PM, V2 said the facility should have had two nurses witnessed and disposed unused residents' narcotic medications appropriately. V2 also said nurses should not have returned unused narcotic medication by applying (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	paper tapes to seal the medication cards for infection control, risk of narcotics diversion, and ensuring the residents receive the correct medication as ordered by the physician, prepared, and packed by pharmacy.The facility's Medication Administration Policy, revised on November 13, 2025, showed, Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to provide foods at a palatable temperature acceptable to the residents. This applies to 13 of 13 residents (R3, R7, R23, R27, R31, R35, R48, R73, R105, R107, R111, R118, R123) reviewed for dining in the sample of 26. The findings include: Facility Fall/Winter menu (Week 3, Tuesday) for lunch included (hot) Italian Beef Sandwich, Potato Wedges, and 3 Bean Salad. During initial tour the following residents stated the food is cold: On December 15, 2025, at 11:00 AM, R105 stated, I eat in the room and dining room. The food is not really hot. On December 15, 2025, at 11:23 AM, R73 stated, Food is high quality, but they have trouble keeping it warm.On December 15, 2025, at 11:39 AM. R111 stated, I eat in the room. Food is not very edible and is cold.On December 15, 2025, at 11:55 AM, R35 stated the food is ice cold. R35 stated she eats in her room and remarked she does not understand why her food is cold, as her room is closer to the kitchen. On December 15, 2025, at 12:17 PM, R23 was eating in dining room and stated the food is usually served cold.On December 16, 2025, at 9:04 AM, R118 stated the food is sometimes served cold. On December 16, 2025, at 9:53 AM, R3 stated the food is sometimes served cold. On December 16, 2025, at 1:30 PM, during Resident Counsel Meeting, R7, R27, R31, R48, R107, R111, R123 stated the food is usually served cold. On December 16, 2025, starting at 11:25 PM, during meal service, the plates were noted heated by a heating lamp above the steam table. Once the food was plated, it was placed on a tray and covered by a metal lid for room trays. These trays were then loaded onto a free-standing cart, and then covered by a plastic liner and rolled unto the unit. On December 16, 2025, at 12:13 PM, the meal temperatures tested by V3 (Dietary Manager) after last meal tray was served and showed Italian roast beef sandwich 104.5 degrees Fahrenheit, potatoes wedges 134.9 degrees Fahrenheit. Other item served was cold item of 3 bean salad. When asked, V3 responded the facility does not have heating pellets for each plate and has only one insulated enclosed cart for the C-Wing. On December 17, 2025, at 9:26 AM, V18 (Dietitian) state the palatability of foods should be between 110-120 degrees Fahrenheit. V18 added the facility does not have a policy for palatability of food.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to provide pureed consistency foods to residents that have a diet order for the same. This applies to 4 of 4 residents (R21, R39, R80, R129) reviewed for pureed diets in the sample of 26. The findings include: Facility Fall/Winter menu (Week 3, Tuesday) for lunch included Italian Beef Sandwich and 3 Bean Salad. On December 16, 2025, at 10:52 AM, during pureed meal prep of Italian Beef in facility kitchen, V4 (Cook) stated she is preparing for 4 residents. V4 placed unmeasured amount of ground Italian beef, that was noted to have charred portions, into the blender along with 4 ounces of beef broth and a tablespoon of thickener. V4 blended the product in the food processor for about 2 minutes and then opened the container and scaped down the sides and processed it again for another minute. V4 then taste tested the product and stated it was ready for service. On taste testing, the pureed beef had coarse particles of charred bits and hardened pieces of meat. V3 (Dietary Manager) was called to the area and notified of the same, and she agreed the item needs to be pureed more. V4 stated she has already pureed the 3-bean salad and placed it in the refrigerator for service. On taste testing the same, the item had pieces of beans that were also visible floating in the pureed mixture. V4 and V3 were notified the item was not safe to serve. V3 agreed that the item needed to be pureed further. On December 17, 2025, at 9:26 AM, V18 (Dietitian) stated the pureed food should be smooth with no texture, like mash potato consistency, and should have no lumps or chewing required. V18 added she will revise the menu to exclude 3 bean salad for the pureed consistency as the kidney beans will be difficult to puree. Facility (undated) policy titled Pureed Food Preparation included:Guideline: Pureed foods will be prepared using standardized recipes to ensure quality, flavor, palatability and maximum nutritive value.Procedure: 6. Pureed foods will be the consistency of applesauce or smooth, mashed potatoes . Pureed Meat Protocol: To ensure proper consistency and nutritional value when pureeing meat.Procedure: 4. If the product is too runny, add thickener; if the product is too thick, slowly add more liquid. The desired consistency should be smooth and should be able to stand alone on the plate. Recipe for Pureed Italian Beef Sandwich included to process until fine in consistency. If thickener is needed, combine thickener and beef broth to obtain pudding like consistency. Facility Diet order listing showed that R39, R80 and R129 were on pureed diets and R21was on pureed meat.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow transmission-based precautions for COVID-19 positive residents. The facility also failed to follow standard infection control practices while handling contaminated medical devices. This applies to 6 of 26 residents (R3, R20, R25, R98, R103, R118) reviewed for infection control in the sample of 26. The findings include: 1. On December 15, 2025, at 10:10 AM, R20 and R98 were sitting in the common area without PPE (Personal protective equipment). R20 was coughing while seated at the table with residents (R6, R63, R64, R76, R84 and R98). V10 (Licensed Practical Nurse/LPN) was in the common area wearing only a surgical mask and stated, The ones with masks have COVID. I can watch them out here versus in the rooms. At 10:12 AM, V31, CNA (Certified Nurse Assistant), entered the common area, donning only a surgical mask. At 11:25 AM, V32 (CNA) entered the common area, donning only a surgical mask with unmasked R93. V19 assisted unmasked residents (R10, R21, R28, R79, R91, R112, and R125) at a table situated across from the table with R20 and R98. On December 16, 2025, at 9:35 AM in the common area, unmasked R20 asked V9, ADON/IP (Assistant Director of Nursing/ Infection Preventionist) for something to eat. V9 stated to R20, Yes, let me get you something to eat. V9 affixed a surgical mask to R20. V13 (CNA) entered the common wearing a surgical mask. At 9:48 AM, V9 brought a box of surgical masks to the common area. V13 and V12 were donning a gown and surgical mask as they applied surgical masks to residents in the common area. On December 16, 2025, at 9:50 AM, V9 (Assistant Director of Nursing /Infection Preventionist) verbalized, Patients with COVID-19 should be wearing a N95 mask; at the very least a surgical mask. The staff should wear a gown, PPE and are encouraged to wear a N95. V9 stated residents who are COVID-19 positive have transmission base precautions signage (contact precautions, droplet precautions and respiratory precautions) placed on the door to alert staff and visitors. V9 provided a document titled Respiratory Line List used for tracking residents and staff who tested positive for COVID-19. V9 states the initial COVID-19 positive case was a staff member on November 14, 2025. The residents are tested twice a week on the night shift. The nurses record the positive results and affix the signage to the residents' doors. R20's EMR (Electronic Medical Record) showed R20 was admitted to the facility on [DATE], with diagnosis of Alzheimer's disease, hypertensive chronic kidney disease, type II diabetes, mood disorder, major depressive disorder, anxiety, difficulty walking and osteoarthritis. The MDS (Minimum Data Set), dated October 10, 2025, showed R20 is severely cognitive impaired and dependent with activities of daily living. The EMR showed an infection note on December 9, 2025, at 1:55 PM, R20 tested positive for COVID-19 and therefore placed on droplet and contact isolation and visitors will wear an N95 mask, gown and gloves. R20's care plan, dated December 10, 2025, showed R20 required Transmission Based Precautions (TBP). The resident requires contact and droplet isolation due to COVID-19 diagnosis. After removing gloves and washing hands, do not touch potentially contaminated environmental surfaces, an effort will be made to place resident in private room, isolation precautions will be discontinued per policy, maintain precautions to minimize the risk of transmission to other residents, remove gloves before leaving the room and wash hands immediately, wear gloves when entering the room if you will have any contact with residents or resident's infected area, and while caring for the resident change gloves and wash hands after contact with infection material. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	EMR (Electronic Medical Record) showed R98 was admitted to the facility on [DATE], with diagnoses of chronic kidney disease, vascular dementia, repeated falls, hypothyroidism and hyperlipidemia, hypertension, and COVID-19. R98's MDS, dated [DATE], showed R98 is severely impaired of cognitive skills for daily decision making and dependent for activities of daily living. The care plan, dated December 8, 2025, showed R98 required Transmission- Based Precautions (TBP). The resident requires contact and droplet isolation due to COVID-19 diagnosis. After removing gloves and washing hands, do not touch potentially contaminated environmental surfaces, an effort will be made to place resident in private room, isolation precautions will be discontinued per policy, maintain precautions to minimize the risk of transmission to other residents, remove gloves before leaving the room and wash hands immediately, wear gloves when entering the room if you will have any contact with residents or resident's infected area, and while caring for the resident change gloves and wash hands after contact with infection material The facility provided their TBP signage posted outside door of R20's and R98's room. The signage had Stop. droplet precautions everyone must: clean their hands, including before and when leaving the room. Make sure their eyes, nose and mouth are fully covered before room entry or remove face protection before room exit. Stop N95 plus eye protection and contact precautions: Everyone must: . Put on a fit -tested N-95 respirator before room entry, (visitors wear a mask).Put on gown before room entry and discard before room exit. Put on eye protection before entry to the room and remove after exit.Stop contact precautions everyone must: clean their hands, including before entering and when leaving the room . Providers and staff must also: Put on gloves before room entry, discard gloves before room exit, put on gown before room entry. discard gown before room exit, do not wear the same gown and gloves for the care of more than one person. The facilities policy titled Transmission-Based (Isolation) Precautions, with a revisions date of October 1, 2024, showed, It is our policy to take appropriate precautions to prevent transmission of pathogens, based on pathogens' modes of transmission. residents on transmission-based precautions should remain in their rooms except for medically necessary care. All staff receive training on transmission-based precautions upon hire and annually. nursing staff receive training on signs and symptoms of infection, common organisms that require additional control measures, and considerations for residents who are colonized with infectious organisms.healthcare personnel caring for residents on contact precautions wear a gown and gloves for all interactions that involve contact with the residents or potentially contaminated areas in the resident's environment. A private room is preferential. when one resident is infected with a pathogen that is transmitted by the droplet route, maintain at least 3 feet of separation between beds. Residents on droplet precautions who must be transported outside the room should wear a facemask and follow respiratory hygiene/cough etiquettes described in the facility's Standard Precautions Infection Control Policy. The Infection Surveillance policy, with a revision dated of October 1, 2024, showed, A system of infection surveillance serves as a core activity of the facility's infection prevention and control program. Its purpose is to identify infections and to monitor adherence to recommended infection prevention and control practices in order to reduce infections and prevent the spread of infections.observations of staff including the identification of ineffective practices. 2. R3's EMR showed R3 was admitted to the facility on [DATE], with diagnoses that included Parkinson's Disease, generalized muscle weakness, and unspecified abnormalities of gait and mobility. R3 tested positive for Covid-19 on December 12, 2025, per the facility line list of Covid positive staff and residents. R3's POS (Physician's Order Sheet) showed Contact/Droplet Isolation Covid-19 every shift for 11 days. The order date showed December 12, 2025, and completion date is (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	December 23, 2025. R118's EMR (Electronic Medical Record) showed R118 was admitted to the facility on [DATE], with diagnoses that included intervertebral disc disorder with radiculopathy, lumbar region, acute respiratory failure with hypoxia, generalized muscle weakness, other chronic pain, dizziness and giddiness. R118 tested positive for Covid-19 on December 6, 2025, per the facility line list of positive staff and residents. On December 15, 16, and 17, 2025, intermittent observations were made of V16 (CNA/Certified Nurse Assistant), V17 (CNA), V19 (LPN/Licensed Practical Nurse), V21 (LPN), and V35 (RN/Registered Nurse) entering R3's and R118's rooms to provide direct patient care without wearing eye protection. Both residents were positive for Covid-19. The signs on the doors indicated they were on Contact and Droplet Transmission Based Precautions. The Droplet precautions signs clearly stated eye protection was to be worn. On December 16, 2025, V36 and V37 (Family member) were in the hallway. Neither was wearing any PPE (Personal Protective Equipment). V37 said her family member was admitted to the facility last night and no one had told them they had to wear a mask when in the facility and moving about the unit. On December 16, at 9:46 AM, V38 (POA/Power of Attorney) and V39 (friend) were visiting R118 in his room. Both visitors were wearing surgical masks only. V39 said no one made them aware they should be wearing gown, gloves, N95 mask, and eye protection before entering the room of a Covid positive resident. V39 said they just put on the mask they were given when they entered the facility by the receptionist. On December 16, 2025, V16 (CNA) was wearing an N95 mask on the unit. She stated no one told her she had to wear a N95 mask except when going into Covid positive rooms. V16 said she chooses to always wear an N95 to protect herself and her family members at home. On December 17, 2025, at 12:02 PM, survey team was made aware that R35 had tested positive for Covid-19 on the midnight shift. Surveyor went to R35's room and V9 (Infection Prevention Nurse) was in R35's room wearing only a N95. The curtain in between the beds was open so both residents were visible from hallway. There was nothing separating R35 and her roommate, who tested negative on the night shift. There were no isolation signs on the door, or isolation cart with PPE (Personal Protective Equipment) outside the room. V17 (CNA) entered the room wearing only a surgical mask and it was pulled down below her nose. V9 exited the room, and she had V17 come out with her. V9 was heard telling V17 that R35 had tested positive for Covid last night so they needed to move the roommate to another room. V9 left and returned with the one sign and put it on the door, it was the Stop everyone must wear N95 plus gown, gloves, and eye protection sign. V17 called over V16 (CNA) and told her R35 had tested positive for Covid on the night shift. V16 and V17 both said no one told them that during the morning shift report. V16 said this is why she wears the N95 mask all the time. At 12:07 PM, V9 said the roommate had tested negative for Covid last night, but was now symptomatic, so V9 said they will not be moving the roommate to another room. V9 said when in the hallway, the staff only need to wear a surgical mask. When going into the Covid rooms, they must wear the gown, gloves, and N95; she did not mention eye protection. Once a resident tests positive for Covid, V9 said she calls the family to let them know and discourages them from visiting. They are told if they come into the facility and enter the Covid positive room, they need to wear the gown, gloves, and N95. If they stay in hallway, they only wear a surgical mask. V9 said even though they have (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	several residents currently positive for Covid-19, she didn't think they could have a separate Covid positive unit. 3. According to the face sheet, R103 has multiple diagnoses including, type 2 (DM) diabetes mellitus, chronic kidney disease, and hypertensive heart disease. R103's POS (Physician Order Sheet) dated November 27, 2024, showed an active order for blood glucose check to be done for R103 before meals. On December 16, 2025, at 11:15 AM, V22 (Nurse) had the medication cart parked in front of R103's door. V22 had gloves on and was performing blood glucose check for R103 in the R103's room. V22 cleaned R103's finger with an alcohol pad, punctured the finger using a lancet (finger stick device), and placed the used lancet on a paper towel on R103's table. V22 squeezed the blood from R103's finger onto the blood glucose meter test strip to obtain R103's blood glucose result. V22 placed the blood glucose meter on the paper towel. V22 then removed the glove from her right hand, picked up the lancet which was used to puncture R103's finger with her right hand without wearing gloves, and held the blood glucose meter with her left-hand as she walked out of R103's room. V22 dropped the used lancet in the trash bag attached to the side of the medication cart and immediately removed the lancet from the trash bag which had other disposed items in it with the same hand without wearing gloves. V22 said the lancet was accidentally dropped into the trash bag. V22 then disposed the lancet in the sharps container above the trash can on the side of the medication cart. V22 performed hand hygiene using hand sanitizer gel, wore gloves, sanitized the glucose meter, removed her gloves, sanitized her hands with hand sanitizer and proceeded to wheel the medication cart to another resident during the medication pass. 4. According to the face sheet, R25 has multiple diagnoses including, type 2 (DM) diabetes mellitus with hyperglycemia, Parkinson's disease, and hypertensive heart disease. R25's POS (Physician Order Sheet), dated June 22, 2025, showed an active order for blood glucose check to be done for R25 before meals and at bedtime. On December 16, 2025, at 11:35 AM, V22 (Nurse) had gloves on and was performing blood glucose check for R25. V22 removed gloves from her right hand after performing blood glucose check for R25 and then picked up the used lancet (finger stick device) used to puncture R25's finger to obtain blood for testing without wearing gloves. V22 then disposed the used lancet in the sharp's container on the side of the medication cart parked outside R25's room. V22 performed hand hygiene using hand sanitizer gel and proceeded to another resident during the medication pass. On December 16, 2025, at 2:33 PM, V2 said V22 should have used a gloved hand to pick up a sharp object such as a lancet that has been contaminated with blood. V2 also said V22 should not have reached into the trash bag without wearing gloves to grab a sharp object contaminated with blood due to the risk of accidental finger stick or puncture. V2 also added V22 should have performed hand hygiene using soap and water after using the hand sanitizer due to possible exposure to blood. The facility's Hand Hygiene Policy, revised on November 3, 2025, showed, Policy: all staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide dignity to a resident during provisions of care.This applies to 1 of 26 residents (R118) reviewed for dignity in the sample of 26.The findings include: R118's EMR (Electronic Medical Record) showed R118 was admitted to the facility on [DATE], with diagnoses that included intervertebral disc disorder with radiculopathy, lumbar region, acute respiratory failure with hypoxia, generalized muscle weakness, other chronic pain, dizziness, and giddiness. R118's MDS (Minimum Data Set), dated October 27, 2025, showed R118 was cognitively intact and was dependent on staff for showering.On December 16, 2025, at 9:04 AM, R118 said there was an incident, he thinks it was maybe two weeks ago, when the CNA (Certified Nurse Assistant), whose name he said he could not remember, took him to the shower room and turned on the water. The CNA told R118 she would be right back; she had to go to the other shower room for another resident. R118 said it was around 15 minutes later when the CNA returned, and he was shivering cold. R118 said he was not able to wash himself, so he was just sitting there naked, waiting, and it was cold. On December 16, 2025, at 2:16 PM, V2 (DON/Director of Nursing) said when giving a resident a shower, the resident should never be left alone in the shower room or left naked. On December 16, 2025, at approximately 3:30 PM, V1 (Administrator) said she spoke with R118, and he pretty much told her the same thing. V1 said it was common sense that the staff member should not have left [R118] in the shower room by himself.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Serenity Estates at Morris	1223 Edgewater Morris, IL 60450

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide services to prevent further contractures for a resident and failed to apply recommended devices to treat a resident's contractures.This applies to 2 of 3 residents (R14 and R15) reviewed for range of motions in the sample of 26. The findings include: 1.R14's face sheet included R14 was admitted on [DATE], with multiple diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, hypomagnesemia, dysphagia following cerebral infarction, personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits, and ataxia following cerebral infarction. R14's quarterly MDS (Minimum Data Set), dated October 31, 2025, showed R14 was moderately impaired in cognition. R14's functional limitation in range of motions showed impairment on one side. On December 15, 2025, at 12:29 PM, R14 was seated in dining room. R14's left arm appeared flaccid with his palm closed in a fist. When asked if he can open his fist, he stated he could not. R14 stated he had a stroke and not able to use left arm. R14 stated he does not receive therapies, and staff does not do any range of motion exercises with him for his left arm/hand. On December 16, 2025, at 10:45 AM, V5 (Certified Nursing Assistant) stated she has never seen R14 with any device on his left hand since she worked at facility in past ten months. On December 16, 2025, at 1:15 PM, when asked if therapy has seen R14 related to his left arm, V6 (Director of Therapy) stated he knows that PT (Physical Therapy) saw him but does not think he was seen by OT (Occupational Therapy). V6 stated he will check his records and give updated information. On December 16, 2025, at 1:53 PM, V6 returned and stated R14 was seen by PT in December 2024 and July 2025, as R14 had a functional decline related to a fall. V6 stated R14 has not been seen by OT earlier and he had asked V7 (Occupational Therapist) to assess him. V6 stated based on V7's assessment, he was told R14 will be appropriate for a wrist and arm splint before the arm/hand gets into a further contracture. V6 stated it was good that it was caught today, or it would have progressed into a contracture. V6 stated he does not know how soon the hand progressed to current state. On December 16, 2025, at 1:53 PM, V7 stated R14 has had PT before but not had OT requested before. V7 stated, It came to my attention today and I got orders from the Nurse Practitioner and went ahead and screened him. I was able to complete the screen and recommended a WHO (wrist hand orthotics) focusing on wrist/hand/digit. He had a neuromuscular palsy from the stroke, and all his flexor muscles are shrinking. If that was not assessed, it will get worse and develop into a flexor contracture. So, since we caught it today in the early stage, we were able to apply a splint with a good fit and no pain. We will monitor everything from hygiene to skin integrity and make sure that it doesn't become a further problem. V7 added, He (R14) was keeping his hand fisted without the device. If he had the splint earlier, it would have prevented that. He does not have any active range of motion now. Occupational Therapy Evaluation and plan of treatment, dated December 16, 2025, included: (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Clinical impressions/reasons for Skilled Services: Patient presents with impairments in balance, gross motor coordination, dexterity, use of environmental modification strategies, strength, follow through, self-modification, mobility and interpersonal care and mobility which requires skilled OT services to assess and modify environmental barriers, restore cognitive and perpetual abilities, provision pain management techniques, improve rehab potential, increase safety awareness, increase functional activity tolerance, facilitate sitting tolerance and postural control assess and modify environmental hazards, assess safety with adaptive equipment, assess the need for adaptations/assistive devises, develop and instruction on adaptation techniques, design and implement Restorative Nursing Program Additional Analysis: Left hand WHO to left hand to prevent contracture (hand weakness). Order details: OT splint schedule for left hand/wrist. Left resting hand splint to be applied in AM (morning) for 3 hours, removed during meals, reapplied in PM (evening) for 3 hours and to monitor hand splint use for proper fit and hygiene to reduce skin breakdown. On December 17, 2025, at 1:05 PM, V2 (Director of Nursing) stated the facility does not have a restorative program and are just about to start one. 2. R15's admission record showed R15 was admitted to the facility on [DATE], with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, weakness, need for assistance with personal care, epilepsy, chronic pain, and fusion of the spine. R15's Minimum Data Set, dated [DATE], showed her to be cognitively intact. R15's occupational therapy (OT) evaluation and plan of treatment notes showed R15's reason for therapy was to address left upper arm flexion contracture R15 started occupational therapy on September 9, 2025 and the goal was R15 would achieve normal anatomical alignment of the left hand for 4 hours using a resting hand splint in order to improve skin integrity and hygiene, and achieve proper joint alignment, and prevent contracture. At that time, they recommended elbow extension orthosis and a resting hand orthosis during night hours. R15 had a point of care task that showed the following: ensure resident Os Calcis Stiffness index (OCSI) brace is applied to her left arm every evening, and off every morning. OCSI symbol should be at the top of her arm. R15 discharge OT summary, dated October 17, 2025, showed the following recommendations: Restorative program Establish/Trained=restorative range of motion program, restorative splint and brace program. 1. Range of motion program established trained: passive range of motion to left shoulders, elbow, wrist, digits to increase range of motion and decrease contractures. 2. Splint and brace program establish/trained splint and brace program 3. Splint and brace program established/trained: R15 is currently able to care for and clean device and apply brace one person assistance. On December 15, 2025, at 11:35 AM, R15 observed with a left-hand closed contracture and a left (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	elbow contracture with left hand at her chest. R15 did not have any splint, brace, or any device on her left arm or left hand. On December 16, 2025, at 10:05 AM, R15 stated she has a brace for her left hand/wrist but no one puts it on because they can't open her hand wide enough to put it on (long arm brace). R15 does not have a brace or anything on her contracted left hand or arm. On December 16, 2025, 11:58 AM, V23(Director of Rehab) stated he believes R15 has had occupational therapy and he does not believe she is on any restorative program. On December 16, 2025, at 12:48 PM, V23 stated upon discharge from occupational therapy, R15 should be wearing a hand brace and arm brace daily per their recommendations. V23 stated the staff were trained on how to apply resident splint. V23 stated the staff were aware she needed the brace. On December 16, 2026 at 2:20 PM, V23 stated R15 had received OT starting September 9, 2025, and they were working to increase her range of motion (ROM) in her left hand, establish an exercise program, and she was to have splints placed with one assistance from staff. On December 16, 2025, at 12:25 PM, V33(Certified Nursing Assistant/CNA) and V34 (CNA) both stated they do not assist R15 with any splints or devices for R15's left hand or arm. V33 and V34 both stated they have not had any direction or education to do so. On December 16, 2025, at 2:26 PM, R15 stated she had 3 splints; no one assists her with putting them on, and she cannot do it by herself. R15 stated her left elbow brace should have been placed every night. R15 stated she is supposed to sleep in it, and no one has put it on her for months and months. R15's resting hand roll splint device for her left hand has a tie to keep it in place. R15 stated she needs assistance to put on because she can't tie/secure it with one hand. R15 had a hand second splint that runs down the dorsal part of her arm (wrist splint) that she stated she is also not wearing because her hand can't open enough to put in on. R15 had third elbow/arm brace that she stated she should be sleeping in it, but no one puts it on. R15 stated she kept asking people to help her to put it on. R15 would have to go looking for them to assist her. R15 stated the staff never approached or asked if she needed assistance and then she just stopped asking. R15 stated they were not putting the elbow brace on correctly and it was cutting off her circulation in her left hand. R15 stated she does not get therapy, and no one works with her doing any range of motion. On December 16, 2025, at 1:55 PM, V23 stated R15's wrist splint was an older one and came into the facility with it. V23 stated R15was no longer able to use it and not able to get her range to use it, so they gave her a new resting hand splint. V23 stated R15 used the new resting hand splint/log device during therapy, and it was to continue after OT stopped. V23 stated they in-service staff to place, but there is normally an order for it to be placed. V23 stated he was not sure when it should be placed it the hand splint. He would ask OT. She is supposed to be wearing both the elbow brace with resting hand brace/splint together. On December 16, 2025, at 2:48 PM, V26, Certified Nursing Assistant/CNA, stated she was not aware R15 had a resting hand/log splint and has never assisted resident in placing it. V26 stated she was never educated on how to assist R15 on putting on either the hand or the elbow brace, and no staff has directed her to put R15's braces on at night. V26 stated once in a while, R15 had asked her to put the elbow brace on. V26 stated the elbow brace is hard to put on. V26 stated she familiar with the task in their point of care charting that refers to placing R15's brace and she does not recall ever clicking on it. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On December 17, 2025, at 1:00 PM, V27 (CNA) stated she does not do anything with R15s' splint or brace for her left hand and elbow. On December 17, 2025, at 1:04 PM, R15 stated no one put either of her braces on yesterday or last night. As of December 16, at 11:38 AM, there was no task or order for placing or assisting in the placement of R15's left hand resting-hand brace/log. R15 had no care plan for her left arm or left-hand contractures. On December 17, 2025, at 2:56 PM, V2 (Director of Nursing) stated they do not have a restorative program. V2 stated she expects the staff to follow therapy recommendations. V2 stated she expects staff to follow therapy recommendation because they are important for the resident's quality of life, to maintain resident range of motion, and enhance their quality of life. V2 stated the CNAs are responsible for the Point of Care tasks including the one for R15's brace placement. The facility's Prevention of Decline in Range of Motion, dated December 4, 2025, showed based on the comprehensive assessment, the facility will provide interventions, exercises and/or therapy to maintain or improve range of motions. b. the facility will provide treatment and care in accordance with professional standards of practice. This includes, but is not limited to: i. appropriate serves (specialized rehabilitation, restorative, maintenance). ii. Appropriate equipment (braces or splints). Iii. Assistance as need (active assisted, passive, supervision).