

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2025
NAME OF PROVIDER OR SUPPLIER Serenity Estates of Lena		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 South Logan Street Lena, IL 61048	
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to prevent staff-to-resident physical and verbal abuse. This applies to 1 of 3 residents (R1) reviewed for abuse in the sample of the 3. The findings include: The facility's Final Report to the local health department (date submitted not provided in report) showed, on 11/8/25 at 4:45 PM, V4 and V5 Certified Nursing Assistants (CNAs) entered R1's room, an incontinent resident, to provide cares and get him ready for dinner. [R1] is resistant often to care, including yelling out when being provided peri care. The report showed V4 indicated V5 became frustrated with [R1's] reluctance of care and quickly pulled the blankets and sheet off him. [R1] then reacted negatively by yelling, again. [V5] then pinched the resident's nose and told [R1] to 'shut up and be quiet' and 'shut the f*** up.' The report showed, Allegations made by [V4] against [V5] are founded. [V5] will not be returning to work at [the facility]. The facility's investigation included V4's Employee Statement (handwritten note signed by V4 on 11/8/25) which showed, 'We (V4 and V5) walked into his room and right off the bat [R1] was a little irritated and did not want to get up for dinner. We told him that he did have to get up because he needs to eat. [V5] then proceeds to throw the blankets off of [R1] and [R1] grunts because she did it aggressively and she then tells [R1] to 'Shut up. Be quiet.' We start to change him and get his pants on and he's still grunting, kind of screeching at this point so I tell [R1] 'I'm sorry. We're not trying to hurt you, just get you changed.' [V5] goes on to say 'shut the f*** up!' and grabs his nose hard and twists it and pulls on his nose. After we are done getting him up, I immediately go to tell [V10] and [V1] about the situation. The investigation showed V5 had received abuse training. On 11/18/25 at 10:10 AM, R1 was alert but pleasantly confused. R1 did not recall the incident on 11/8/25. R1 began speaking about a man helping him downtown. R1 had no injuries to his nose or face. On 11/18/25 at 11:19 AM, V4 CNA stated she has worked at the facility for a year, and she has been a CNA for two years. V4 stated she had only worked with V5 CNA one other day prior to 11/8/25. V4 said on that training day (V5 was a new employee to the facility) V5 was telling residents to be quiet and she doesn't want to hear them. V4 stated these statements were reported to a supervisor. V4 stated the next day she worked with V5 was on the afternoon of 11/8/25. V4 stated on that afternoon she went to assist V5 with getting R1 ready for supper. V4 stated R1 moans and groans while the staff provide care and get him up. V4 stated all of the staff are aware of R1's behaviors during care and she believes it is due to his catheter, which irritates him. V4 stated V5 kept telling R1 to be quiet and to shut the f*** up. V4 stated, She did actually use that word. I'm not a confrontational person. I was very shocked when she said that. I should have stopped her at that time. V4 stated, after that statement they continued to get R1 ready and transfer him out of bed with a mechanical lift. V4 said V5 was operating the mechanical lift, R1 was continuing to moan, V5 reached around the mechanical lift and grabbed his nose, twisted it, pulled it, and told him to be quiet. V4 said, there is no question in my mind as to what [V5] was doing (when she grabbed R1's nose). She was trying to get him to be quiet through twisting and pulling his nose. When she did that he squealed. V4 said after the physical abuse she separated R1 from V5, reported the incident, and then V5 was escorted from the building. On 11/18/25 at 10:21 AM, (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 146114
		If continuation sheet Page 1 of 2

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V5 CNA stated R1 .cussed me out V5 stated she is used to racial slurs, and it does not affect her ability to provide care. V5 denied the incident and stated the facility is lying. On 11/18/25 at 11:52 PM, V10 CNA Supervisor stated, I've never had a problem (with V4). She is respectful and quiet. She has never made an allegation against another staff member that I know of. V10 said V5 has very poor customer service. V10 said her demeanor and speech came off as lacking compassion; she would talk to them (residents) like children. I did hear her tell a resident that they should not be using their call light constantly because she had things to do. I pulled her aside and told her that we need to encourage the residents to use the call lights for safety and she cannot say that to the residents. She said she felt like she was going to get fired and she was fired from her previous job. She actually told me that. V10 stated V5 told her at her previous facility herself and other CNAs would turn off the call light system when residents would continue to use the call light. V10 said that 11/8/25 was V5's first day off training. V10 said it is known by the staff that R1 does not like to be repositioned and he moans during care. V10 said V4 reported to her that V5 had told R1 to shut the h*ll up and that V5 pinched and pulled his nose. V10 said R1 and V5 were separated then V5 was escorted from the building. V10 said R1 was upset and riled up following the incident; however, by the time supper was over he was at his baseline. V10 said she did not see any facial trauma on R1. On 11/18/25 at 12:10 PM, V11 Registered Nurse (RN) stated she escorted V5 from the facility on 11/8/25. V11 stated she had not worked with V5. V11 stated, .[V4] is a sweet girl. She does her job. V11 stated R1 does moan and groan during care due to his catheter. V11 stated R1 is receiving an ointment for his catheter discomfort. V11 stated she assessed R1 after the incident and he was aggravated. On 11/18/25 at 9:41 AM, V6 R1's Power of Attorney/R1's Daughter stated she did not see R1 until the following Wednesday. (11/8/25 was a Saturday). V6 stated, her brother, R1's Son, was in the facility shortly after the incident and R1 reported to him there had been a ruckus. V6 stated she did not see any injuries to R1's face. V6 said if this incident had occurred to R1 and he was cognitively intact, he would have been upset; however, there would not have been any lasting consequences to his behavior or mood. V6 said R1 has been experiencing a recent decline in cognition and health. On 11/18/25 at 9:59 AM, V7 R1's Son stated he saw R1 on Monday, 11/10/25. V7 stated, R1 reported there had been a ruckus but could not provide any further details. V7 stated R1 had no injuries to his face, and he would have shrugged off an incident like this if he was cognitively intact. V7 stated R1 has started to experience a recent decline in his health and cognition. On 11/18/25 at 8:33 AM, V1 Administrator stated V4 was a trusted and valued staff member. V1 stated he believed V4's statement and substantiated the abuse. On 11/18/25 at 12:10 PM, V2 Director of Nursing stated V4 .is one of our best. R1's admission Record (Face Sheet) showed he was admitted to the facility on [DATE] with diagnoses to include but not limited to dementia, psychosis, and pain. R1's 9/2/25 Quarterly Minimum Data Set showed, during the assessment period, he had moderate cognitive impairment. The facility's Abuse policy (Dated 2/17/2020) showed, Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. It included verbal abuse, sexual abuse, physical abuse and [NAME] abuse. The policy continued, Employees are required to report all incidents of possible abuse, mistreatment or neglect of any resident. The policy showed accused staff should be removed from the facility and suspended.		