STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014377	A. BUILDING: _____ B. WING _____	C 12/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY ESTATES OF LINCOLNSHIRE	150 JAMESTOWN LANE LINCOLNSHIRE, IL 60069

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S 000	Initial Comments Facility Reported Incident of 11/14/24/IL181443	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210a) 300.1210b) 300.1210d)6) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999		

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resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These regulations were not met as evidenced by:

Based on interview and record review, the facility failed to ensure resident was assisted and supervised while ambulating to her room for 1 of 3 residents (R3) reviewed for safety and supervision in the sample of 6 residents. This failure resulted in R3 falling and sustaining subarachnoid and subdural hemorrhages.

The findings include:

On 12/2/24 at 10:16 AM, V14, Director of Nursing (DON) at the time of R3's fall, said V12, Licensed Practical Nurse (LPN), and V13, Nursing Supervisor, called her (on 11/14/24) and said R3 was found on the floor. V14 said V12 and V13 told her R3 was last seen walking toward her room after dinner. V14 said R3's fall was not witnessed, but the nurses had seen R3's drawers were still open, so they assumed she was trying to get something out of them and lost her balance and fell.

On 12/2/24 at 11:10 AM, V11, LPN, said she

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came in to work at 11:00 PM on the night R3 fell. V11 said R3 was already gone to the hospital at that time. V11 said she called the hospital to follow up and see how R3 was doing, and the hospital staff told her R3 was being admitted to the ICU (Intensive Care Unit)with a subarachnoid hemorrhage and a subdural hematoma. V11 said staff know what level of care a resident requires by looking at the resident's care plan and by staff-to-staff report. V11 said R3 had cognitive problems.

On 12/2/24 at 12:17 PM, V10, Restorative Director/LPN, said after a resident falls, he works with the DON to come up with interventions for the resident's care plan to prevent another fall/injury. V10 said R3 is a fall risk and needs supervision when ambulating. V10 said R3 previously fell on July 20th (2024) and her care plan was updated at that time to include assisting her to her bedroom before and after meals. V10 said staff should walk R3 to her room before and after meals, R3 needs supervision for transfers (moving from the chair to bed, bed to a chair), ambulation, and toileting hygiene. V10 said R3 is not independent; she needs supervision for most of her ADLs (activities of daily living). V10 said supervision is stand by assistance, then he pointed to number 4 on a sign on his office door and said that is supervision. The sign read as follows: Supervision or touching assistance-Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.

The facility's Un-witnessed Fall report dated 11/14/24 at 7:00 PM shows R3 was seen walking towards her room with her rolling walker. R3 was

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later found lying flat on her back on the floor. R3 was assessed and a bump was found on the back of R3's head. The report noted predisposing physiological factors including confusion and impaired memory, and predisposing situation factors including ambulating without assist. The facility's Final Report dated 11/20/24 shows R3's fall was attributed to R3 suddenly losing her balance when she was ambulating.

R3's current care plan provided by the facility shows R3 is a high risk for falls related to a history of falling, difficulty in walking, and lack of coordination. The goal is that she will not sustain serious injury. The following intervention was initiated on 7/22/24: Assist R3 to walk to her bedroom before and after meals. She is on supervision for toileting hygiene, transfers, and ambulation. R3's Minimum Data Set (MDS) dated 11/11/24 shows R3 requires Supervision or Touching assistance for sit to stand, chair/bed to chair transfer, toilet transfer, and walking 10, 50, or 150 feet. The MDS also shows R3 has severe cognitive impairment. R3's eInteract SBAR (Situation-Background-Assessment-Recommend ation) Summary for Providers dated 11/14/24 at 10:48 PM shows R3's diagnoses include, but are not limited to, abnormalities of gait and mobility, unsteadiness on feet, and right and left knee arthritis.

R3's ED (Emergency Department) to Hosp(Hospital)-Admission dated 11/14/24 shows R3 presented to the ED after an unwitnessed fall where she was found lying on the floor beside her bed with her head near the foot of the bed around 7:00 PM. R3 has a history of dementia. R3's head CT shows a subdural hemorrhage and a subarachnoid hemorrhage.

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