Illinois D	epartment of Public	Health			FORM	IAPPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		IL6014377	B. WING			C 02/2024
	PROVIDER OR SUPPLIER			STATE, ZIP CODE	12/	02/2024
		150 JAM	ESTOWN LA			
SERENII	Y ESTATES OF LINC	LINCOLN	SHIRE, IL 6	0069		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	Facility Reported In	cident of 11/14/24/IL181443				
S9999	Final Observations		S9999			
	Statement of Licen	sure Violations				
	300.1210a) 300.1210b) 300.1210d)6)					
	Section 300.1210 Nursing and Person	General Requirements for nal Care				
	facility, with the part the resident's guard applicable, must de comprehensive car includes measurab meet the resident's and psychosocial n resident's compreh allow the resident to practicable level of provide for dischard restrictive setting b needs. The assess the active participal resident's guardian	nsive Resident Care Plan. A ticipation of the resident and dian or representative, as evelop and implement a e plan for each resident that le objectives and timetables to medical, nursing, and mental eeds that are identified in the ensive assessment, which o attain or maintain the highest independent functioning, and ge planning to the least ased on the resident's care sment shall be developed with tion of the resident and the or representative, as n 3-202.2a of the Act)				
	care and services t practicable physica well-being of the re each resident's cor plan. Adequate and care and personal	shall provide the necessary o attain or maintain the highest I, mental, and psychological sident, in accordance with nprehensive resident care I properly supervised nursing care shall be provided to each				
	tment of Public Health / DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE
	ically Signed					12/20/24
STATE FOR	N		6899	TKZC11	If continu	ation sheet 1 of st

Illinois Department of Public Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					B) DATE SURVEY COMPLETED	
		A. BUILDING.			<u> </u>	
IL6014377		B. WING			C 12/02/2024	
PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
Y ESTATES OF LINC	OLNSHIRE					
SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
		PREFIX TAG	CROSS-REFERENCED TO 1	THE APPROPRIATE	COMPLET DATE	
Continued From pa	ge 1	S9999				
nursing care shall in following and shall	nclude, at a minimum, the be practiced on a 24-hour,					
to assure that the re as free of accident nursing personnel s that each resident r	esidents' environment remains hazards as possible. All shall evaluate residents to see eceives adequate supervision					
These regulations v	vere not met as evidenced by:					
failed to ensure res supervised while an 3 residents (R3) rev supervision in the s failure resulted in R	ident was assisted and nbulating to her room for 1 of <i>v</i> iewed for safety and ample of 6 residents. This 3 falling and sustaining					
The findings include	e:					
(DON) at the time of Practical Nurse (LP Supervisor, called h was found on the fle told her R3 was las room after dinner. V witnessed, but the n were still open, so t	of R3's fall, said V12, Licensed N), and V13, Nursing her (on 11/14/24) and said R3 bor. V14 said V12 and V13 t seen walking toward her /14 said R3's fall was not hurses had seen R3's drawers hey assumed she was trying					
	OF CORRECTION PROVIDER OR SUPPLIER TY ESTATES OF LINC SUMMARY STA (EACH DEFICIENCY REGULATORY OR LA Continued From par resident to meet the care needs of the re- d) Pursuant to nursing care shall in following and shall in seven-day-a-week in 6) All necessand to assure that the re- as free of accident nursing personnel so that each resident re- and assistance to portions we Based on interview failed to ensure resonal so supervised while arrow 3 residents (R3) re- supervision in the so failure resulted in Re- subarachnoid and so The findings included On 12/2/24 at 10:16 (DON) at the time of Practical Nurse (LPF) Supervisor, called from was found on the flot to der R3 was lass room after dinner. A witnessed, but the re- were still open, so to to get something out-	OF CORRECTION IDENTIFICATION NUMBER: IL6014377 IL6014377 PROVIDER OR SUPPLIER STREET AT 150 JAM LINCOLN CY ESTATES OF LINCOLNSHIRE 150 JAM LINCOLN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 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 supervised 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 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	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: IL6014377 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST YESTATES OF LINCOLNSHIRE 150 JAMESTOWN LAN LINCOLNSHIRE, IL 60 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 1 S9999 resident to meet the total nursing and personal care needs of the resident. S9999 () 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: S9999 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. N These regulations were not met as evidenced by: Based on interview and record review, the facility failed to ensure resident was assisted 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 X12 and V13 told her R3 was last seen walking toward her room after dinner. V14 said R3'	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: IL6014377 B. WING 'ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE Y ESTATES OF LINCOLNSHIRE 150 JAMESTOWN LANE LINCOLNSHIRE, IL 60069 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX PROVIDER'S PLAN OF (EACH ORRECTIVE ACT COOSS-REFERENCED TO TO DEFICIENCY Continued From page 1 S9999 resident to meet the total nursing and personal care needs of the resident. S9999 (1) 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: S9999 (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 levaluate resident to see that each resident teceives adequate supervision and assistance to prevent accidents. See These regulations were not met as evidenced by: Based on interview and record review, the facility failure resulted in R3 falling and sustaining 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 Superv	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: 12//1 IL6014377 B. WING 12//1 PROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE Y ESTATES OF LINCOLNSHIRE 15// JAMESTOWN LANE ID ILROCH DEFICIENCY MUST BE PRECEDED BY FULL PRECINATION NOULD BE CROSS-REFERENCE TO FOR SPLAN OF CORRECTION ON SHOULD BE Continued From page 1 S9999 CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY Continued From page 1 S9999 S9999 Sector And	

TKZC11

Illinois Department of Public Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014377		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		B. WING		C 12/02/2024			
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
SERENIT	TY ESTATES OF LINC		ESTOWN LAN NSHIRE, IL 60				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
S9999	V11 said R3 was al	ige 2 11:00 PM on the night R3 fell. ready gone to the hospital at she called the hospital to	S9999				
	hospital staff told he the ICU (Intensive of hemorrhage and a staff know what lev by looking at the re	ow R3 was doing, and the er R3 was being admitted to Care Unit)with a subarachnoid subdural hematoma. V11 said el of care a resident requires sident's care plan and by V11 said R3 had cognitive					
	Director/LPN, said a with the DON to con- the resident's care fall/injury. V10 said supervision when a previously fell on Ju plan was updated a her to her bedroom said staff should wa after meals, R3 new (moving from the cl ambulation, and toi not independent; sh of her ADLs (activit supervision is stand pointed to number and said that is sup follows: Supervision assistance-Helper touching/steadying assistance as resid	7 PM, V10, Restorative after a resident falls, he works me up with interventions for plan to prevent another R3 is a fall risk and needs imbulating. V10 said R3 uly 20th (2024) and her care at that time to include assisting before and after meals. V10 alk R3 to her room before and eds supervision for transfers hair to bed, bed to a chair), leting hygiene. V10 said R3 is ne needs supervision for most ies of daily living). V10 said d by assistance, then he 4 on a sign on his office door pervision. The sign read as n or touching provides verbal cues and/or and/or contact guard lent completes activity. provided throughout the					
	11/14/24 at 7:00 PN	ently. Inessed Fall report dated A shows R3 was seen walking vith her rolling walker. R3 was					

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C			
	IL6014377		B. WING			12/02/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
SERENI	TY ESTATES OF LINC		STOWN LAN SHIRE, IL 60				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
\$9999	later found lying flat was assessed and a back of R3's head. physiological factors impaired memory, a factors including am facility's Final Repor fall was attributed to balance when she v R3's current care pl shows R3 is a high history of falling, diff coordination. The g serious injury. The f initiated on 7/22/24: bedroom before and supervision for toile ambulation. R3's Mi 11/11/24 shows R3 Touching assistance chair transfer, toilet or 150 feet. The ME cognitive impairmer (Situation-Backgrou ation) Summary for 10:48 PM shows R3 not limited to, abnor unsteadiness on fee arthritis. R3's ED (Emergence Hosp(Hospital)-Adn R3 presented to the where she was four bed with her head m 7:00 PM. R3 has a	on her back on the floor. R3 a bump was found on the The report noted predisposing s including confusion and and predisposing situation abulating without assist. The rt dated 11/20/24 shows R3's o R3 suddenly losing her vas ambulating. an provided by the facility risk for falls related to a ficulty in walking, and lack of oal is that she will not sustain following intervention was Assist R3 to walk to her d after meals. She is on ting hygiene, transfers, and inimum Data Set (MDS) dated requires Supervision or e for sit to stand, chair/bed to transfer, and walking 10, 50, DS also shows R3 has severe at. R3's eInteract SBAR und-Assessment-Recommend Providers dated 11/14/24 at B's diagnoses include, but are malities of gait and mobility, et, and right and left knee	\$9999				

TKZC11

PRINTED: 01/07/2025 FORM APPROVED

Illinois Department of Public Health									
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:						
		IL6014377	B. WING		C 12/02/2024				
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
SERENI	SERENITY ESTATES OF LINCOLNSHIRE 150 JAMESTOWN LANE LINCOLNSHIRE, IL 60069								
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE				
S9999	Continued From pa	ge 4	S9999						
		(A)							
llinois Depa	tment of Public Health		1						

TKZC11