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 04/17/2025

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 Investigation of Facility Reported Incident of 4/10/25/IL190064	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6) 300.1210c) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. Section 300.1210 General Requirements for Nursing and Personal Care 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 resident to meet the total nursing and personal care needs of the resident.	S9999		

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c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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 evidence by:

Based on observation, interview, and record review the facility failed to ensure a resident who is a high risk for falls was supervised and failed to ensure fall interventions were individualized for a resident with poor safety awareness and cognitive deficits and failed to ensure bed rails were installed in manner to prevent entrapment. This failure resulted in R1 being found in her room kneeling on the floor with her right arm trapped between the side rail and the mattress sustaining a right comminuted humerus fracture. This applies to 1 of 3 resident (R1) reviewed for safety in the sample of 9.

The findings include:

R1's Final Incident Report dated 4/15/25 shows on 4/10/25 (R1) is a 92-year-old female with diagnoses including atrial fibrillation, type 2 diabetes, major depressive disorder, insomnia, hypertension, and dementia with agitation ...(R1)

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usually transfers with partial to moderate one staff assist and can use call to alert staff when assistance is needed. (R1's) call light was activated, and the nurse (V3-Licensed Practical Nurse-LPN) responded to the light. (R1) was observed kneeling on the floor next to her bed with the wheelchair behind her. (R1's) right arm was between the side rail and the mattress and (R1) was complaining of pain to the right shoulder ...(R1) was sent to the local hospital and admitted with diagnosis of right humerus fracture.

On 4/16/25 at 9:45 AM, R1's bed was observed with two ½ side rails in an upright position. There was a gap (wide enough for her arm to fall through to get trapped) between the mattress and the side rail.

On 4/16/25 at 11:53 AM, V3 (Licensed Practical Nurse-LPN) said on 4/10/25, she did not see R1 go back to her room after dinner. She heard R1 was yelling "help me, help me" and the call light alarming from the room. When she entered the room R1 was on her knees with her wheelchair behind her, her right arm was stuck between the mattress and the side rail. R1's ½ side rail was in the upright position, and she was complaining of pain to her right arm and she could not move her right arm. She asked R1 what happened and R1 could not tell her what happened. V3 said it looked like R1 slide from the bed or was transferring to the bed. R1 was having problems moving her right arm and she was transferred to the local hospital. We remind R1 to use her call light, but she likes to be independent. R1 does not need assistance with transfers and can transfer herself. R4 (R1's roommate) had activated the call light not R1, when she entered the room R4's call light was alarming. Frequent monitoring and supervision could have prevented

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the incident with R1.

On 4/16/25 at 11:41 AM, V4 (Certified Nursing Assistant-CNA) said on 4/10/25, after passing the meal trays, she went to another resident's room to assist with feeding. V3 (LPN) reported she needed help with R1. When she entered R1's room she saw her kneeling on the floor, her right arm was stuck between the side rail and mattress, and she could not move her arm. She was saying, "help me, help me." R1's call light was not activated, her roommate R4's call light was alarming. R1 "never" calls for help, she transfers herself, and does not staff assistance with transfers. She is not a fall risk.

On 4/16/25 at 12:12 PM, R4 (R1's roommate) said on 4/10/25, she heard R1 fall but did not see what happened because the privacy curtain was pulled. R1 was yelling out so loud and she alerted the call light.

On 4/16/25 at 10:18 AM, V5 (Registered Nurse-RN) said he is the nurse on this unit and splits between two units and so does the CNA. R1 is alert and forgetful, she self-propels in her wheelchair. We remind her to use her call light, but she does not remember to use it and he is not sure if R1 knows how to use the call light. She forgets where her room is and asks the same question over and over again. She tries to stand and self-transfer and forgets she needs assistance. She does not use her call light for assistance, she needs to be supervised. If she is left alone, she will attempt to get up.

On 4/16/25 at 10:22 AM, V6 (CNA) said R1 is alert to self, but forgetful. We tell her to use her call light, but she does not use her light for assistance. R1 is one-person extensive assist,

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she is weak and does not ambulate. We toilet her after meals and lay her down.

On 4/16/26 at 3:02 PM, V2 (Director of Nursing-DON) said R1 is high fall risk, she has alert and forgetful and reports her needs to staff. Staff reported R1 she can safely transfer herself and she is not sure if consents need to be obtained for the use of side rails.

R1's X-ray report dated 4/10/25 shows comminuted fracture (a bone broken in at least two places) of the right humeral neck.

R1's Fall Risk Assessment dated 3/3/25 shows R1 is a High Risk for Falling, her gait is weak, and she overestimates or forgets her limits.

R1's current care plan shows she has self-care performance deficit related to dementia ...she requires partial/moderate assistance with transfers, toileting and bed mobility. R1 is non-complaint to ask for assistance for help to her ADLs (activities of daily living) related to her dementia and poor safety awareness. R1's care plan shows she is a HIGH fall risk related to dementia ...prefers to do things herself then requesting for staff assistance, her interventions include encourage her to use her call light for assistance, items within reach and remind R1 to request staff for assistance with toileting and to use her call light to alert staff (same intervention listed twice).

R1's current care plan shows R1 may need to use bilateral half side rails to enhance functional independence and promote skin integrity with interventions include side rails as assistive devices to help to turn and reposition for transfers and demonstrate her to take full advantage of the

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side rails for positioning, turning, and transfers. May need on-going education on the use of the side rails.

The facility's Proper Use of Bed Rails policy dated 9/2024 states, "It is the policy of this facility to utilize a person-centered approach when determining the use of bed rails. Appropriate alternatives are attempted prior to installing or using bed rails. If bed rails are used, the facility ensure the correct installation, use and maintenance of the rails ...the resident assessment should assess the resident's risks of entrapment between the mattress and bed rail or in the bed rail itself .... Informed Consent form the resident or resident representative must be obtained after appropriate alternatives have been attempted prior to installation and use of bed rails ....the information that the facility should provide to the resident, or resident representative includes but is not limited .....the residents benefits from the use of bed rails ...the residents risks form the use of bed rails ....upon receiving informed consent, the facility will obtain a physician's order for he use of the specified bed rail and medical diagnosis, condition, symptom or functional reason for the use of the bed rails ...Installation and Maintenance of Bed Rails ....the facility will assure the correct installation and maintenance of bed rails prior to use. This includes ensuring the bed frame, bed rail and mattress do not leave a gap wide enough to entrap a residents head or body, regardless of mattress width, length or depth .... the facility will follow manufactures recommendations/instructions regarding disabling or tying rails down ...."

The Fall Prevention Program Policy revised 2024 states, "Each resident will be assessed for fall

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S9999	Continued From page 6 risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls ....High Risk Protocols the resident will be placed on the facility's fall prevention program ...provide additional interventions that address unique risk factors measured by the risk assess mention tool ...provide additional interventions as directed by the residents assessment, including but not limited to: assistive devices, increased frequency of rounds, sitter if needed, medication regime review, low bed, alternate call system access, scheduled ambulation or toileting assistance, family/caregiver or resident education, therapy services referral ...interventions will be monitored for effectiveness. The plan of care will be revised as needed." (B)	S9999		