

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058793		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/11/2026	
NAME OF PROVIDER OR SUPPLIER SERENITY ESTATES OF LINCOLNSHIRE				STREET ADDRESS, CITY, STATE, ZIP CODE 150 JAMESTOWN LANE , LINCOLNSHIRE, Illinois, 60069			
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S0000	Initial Comments Complaint Investigation 3611476/27734921		S0000			02/18/2026	
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)3) 300.1210d)6) 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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be		S9999			02/18/2026	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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 requirements are not met as evidenced by: Based on interview and record review the facility failed to ensure a resident with cognitive impairment did not elope the facility and failed to ensure all residents were accounted for one of three residents (R1) reviewed for safety/supervision in the sample of seven. Findings include: R1's Admission Record shows she was admitted to the facility on October 1, 2025, with diagnoses including left femur fracture, urinary tract infection, unsteadiness on feet, anxiety disorder, malnutrition, dementia, alcohol abuse, pulmonary fibrosis, and altered mental status. R1 Elopement Risk Assessment dated October 3, 2025, shows R1 has a high risk of elopement. R1's Minimum Data Set dated January 8, 2026, shows that R1 is not cognitively intact. On February 5, 2026, at 1:01 PM, V6 Certified Nursing Assistant (CNA) said R1 is able to wheel herself in the wheelchair. V6 said R1 likes to wander the facility. On February 5, 2026, at 2:21 PM, V8 Licensed Practical Nurse (LPN) said R1 wanders the building by self propelling in her wheelchair. The facility's "Walkers" binder that is left near the receptionist desk and includes pictures and face sheets of residents that wander, was reviewed on February 9, 2025. R1's picture was not included in this binder. R1's Care Plan initiated October 1, 2025, shows R1	S9999					

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S9999	Continued from page 2 demonstrates cognitive impairment and R1 is at risk for falls related to current medication use, poor safety awareness, unsteady gait, decline in functional status, dementia, hip fracture, history of falls, and poor safety awareness. R1's Certified Nursing Assistant task documentation dated January 13, 2026, and January 14, 2026, shows R1 had behaviors of elopement. R1's Chronic Care Management note entered by V11 Nurse Practitioner (NP) dated January 29, 2026, shows R1 has severe impairment of cognitive status. R1's Acute Care Note dated February 1, 2026, entered by V11 NP shows that R1 was disoriented. R1's Incident Note dated February 4, 2026, at 9:07 AM entered by V3 Registered Nurse (RN) shows R1 was seen in bed asleep at 4:00 AM. V3 was notified by the police around 6:00 AM that R1 was taken to the local emergency room. R1 was observed by the police outside of the facility. On February 5, 2026, at 1:21 PM, V9 Police Officer said the previous day (February 4, 2026) a concerned passerby called 911 and reported a person sitting in a wheelchair in the cold. V9 said they originally received the call at 5:42 AM and V9 got there at 5:43 AM. V9 said he was nearby to the area. V9 said when he got there, there was a sweater on the ground near R1. V9 said R1 was disoriented and very cold and smelled like urine. V9 said R1's pants were wet in the groin area presumably with urine due to the strong urine smell. V9 said R1 had a thin sweater on. V9 said he did not know where R1 came from. V9 said R1 was sitting in a wheelchair about a block away from the facility. V9 said R1 had no winter gear on. V9 said R1 told him she was outside all night. V9 said R1 was shivering and had a shaky voice because it was cold outside. V9 said that R1 did not know where she lived nor did R1 say where she was going. V9 said he gave R1 his coat when R1 got into his police car to warm her up. V9 said the fire department came quickly and brought R1 to the hospital to be evaluated. V9 said he went to the facility after the fire department took R1 to the hospital. V9 said he talked to V3 Registered Nurse (RN), V4 RN, and V5 Certified Nursing Assistant (CNA). V9 said V4 RN was his first contact when he got to the facility. V9 said the facility did not know that R1 left the facility. V9 said that an exit door alarm went off about 3:30 AM, but the staff was unable to confirm the cause or origin of the alarm. V9 said that V3 RN reported to him that she turned off an exit door alarm but did not see			S9999			

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S9999	Continued from page 3 anything. V9 said he went back by the facility to see if he could figure out what direction R1 took when she left the facility. V9 says he believes R1 left near the employee exit door because the sidewalk was not shoveled. V9 said he saw R1's wheelchair markings in the snow. V9 said the outside temperature was 17 degrees (Fahrenheit/F) because he looked it up when they picked up R1. An observation was made of the sidewalk that R1 potentially took. There were a couple of broken areas of concrete and also unlevel concrete. The sidewalk goes around the facility to the back of it which leads into a parking lot of a shopping plaza. On February 9, 2026, at 9:21 AM, V4 Registered Nurse (RN) said one of the staff members in the facility called her and reported that there was a police officer (V9) at the facility. (On February 4, 2026) V4 said she was the nursing supervisor on that shift. V4 said the police officer got to the facility around 6:00 AM. V4 said the police officer was asking about R1. V4 said she was not aware of the resident, so she looked up the resident's name in the computer and saw that R1 was a resident in the facility. V4 said she called R1's nurse which was V3 RN. V3 came to talk to V9 police officer. V4 said the staff did not know that R1 was gone out of the facility until the police officer came to the facility nor does anyone know what time R1 got out of the facility. V4 said all of the exit doors have alarms on them for when someone exits the facility. V4 said she did not hear any alarms going off. V4 said if a door alarm goes off, then all staff perform a head count on the residents to make sure they are all there. V4 said she was never notified that an alarm went off, nor did she perform a head count on the units she was responsible for. On February 9, 2026, at 9:07 AM, V3 Registered Nurse (RN) said that R1 self propels herself in her wheelchair. V3 said a police officer arrived to the facility around 5:30 AM and said a resident had gotten out of the facility and was taken to the hospital. V3 said she made her last rounds at 4:00 AM, and R1 was asleep in her bed. V3 said no staff knew that R1 had gotten out of the facility. V3 said she did not know what door R1 left out of. V3 said all exit doors are alarmed. V3 said the main exit door alarmed at about 3:00 AM/3:20 AM. V3 said she shut the alarm off, looked outside, and did not see anyone. V3 said it was "very cold outside." V3 said all the residents were counted after the alarm went off but she did not report the alarm to the nurse on the other units. V3 said she called the local hospital after she was made aware that	S9999					

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S9999	Continued from page 4 R1 had exited the facility. V3 said the hospital told her that R1's body temperature was low. V3 said the typical procedure for when an alarm goes off is to let all the staff know so that a head count can be performed. On February 5, 2026, at 2:02 PM, V5 Certified Nursing Assistant (CNA) said she last checked on her residents around 3:45 AM and R1 was in her bed asleep. R1's door was closed. V5 said they were made aware that a resident left the facility when the police officer (V9) came to the facility. V5 said they do not know how R1 got out of the facility. V5 said she did not recall any exit door alarms going off. V5 said an exit door would alarm if a resident got out. V5 said if an alarm goes off, the nursing supervisor will go to the door. V5 said the facility staff perform a head count of all of the residents. V5 said she was made aware of a door alarm that had sounded about 3:45 AM (conflicting statement) and the staff performed a head count. V5 said all the residents were there. V5 said that R1 is able to get in and out of bed on her own and self propels in her wheelchair. V5 said R1 cannot walk and R1 is disoriented and confused at times. R1's Emergency Medical Service (EMS) Report dated February 4, 2026, shows that EMS arrived on the scene with R1 at 5:55 AM. "Patient condition: Complaint: Cold exposure, primary symptoms: Chills." R1 was confused. Assessment Summary: Skin cold. "Narrative: Dispatched for a check for wellbeing. Upon arrival, crew made contact with the patient who was awake and alert, talking with cops. The patient informed the crew that she had been outside all night. The patient informed the crew that she had been living outside for a couple of months. Patient informed crew she felt cold. Provider Impression: Primary: Hypothermia-Initial Patient Acuity: Emergent." R1's Emergency Room Department Notes dated February 4, 2026, at 6:19 AM shows R1 presented to the emergency department for cold exposure. At 9:07 AM, a repeat temperature was taken and "it was continuing to improve." There was no temperature values located in this document. R1's Discharge paperwork dated February 4, 2026, shows R1's rectal temperature upon discharge was 95.9 degrees F. (Rectal temperature=most accurate body temperature location. Normal rectal temperature=99.6-100.4 F) On February 9, 2026, at 12:03 PM, V10 Business Office Manager said V1 Administrator notified her that R1 was in the emergency room and V1 asked V10 if she could go	S9999					

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S9999	Continued from page 5 to the emergency room to check on R1. V10 said she got to the emergency room a few minutes before 7:00 AM. V10 said R1 had been at the emergency room for about 54 minutes by the time she arrived. V10 said R1 slept after she ate breakfast while in the emergency department. V10 said R1 was hooked up to a heart monitor, and the hospital staff were monitoring R1's body temperature. V10 said hospital staff did an oral temperature which read 93 degrees F. The hospital staff were unsure if R1 had the thermometer under her tongue, so they took a rectal temperature which was 95.9 degrees F (an hour or more after resident arrived to the emergency department). V10 said R1 had 2-3 blankets on top of her and the hospital staff also placed a special blanket on top of R1 that blew warm air. On February 9, 2026, at 12:23 PM, V11 Nurse Practitioner said she heard that R1 exited the facility. V11 said that R1 used to be homeless before she became a resident of the facility. V11 said R1 would not be able to be on her own safely due to R1's cognition. V11 said residents should not be able to go out of a facility if the facility is secured. V11 said R1 was able to leave the facility with an escort: family or friend. V11 said residents with cognitive issues have an escort when they leave the facility for safety reasons. V11 said if a resident is found outside in temperatures less than 20 (degrees F), hypothermia would be a concern for her. V11 said a body temperature below 95 degrees (F) is considered hypothermia. On February 9, 2026, at 11:25 AM, R1 said she has been at the facility for "Two weeks, I think. But I don't even have a room anymore. They took it away from me." When R1 was asked if she remembered when she went outside in the cold the other day, R1 said, "I have no idea what you are talking about." R1 was asked if she ever goes outside, and R1 said, "I go smoke a couple times a day. I just go out the front door when I want." R1 has not smoked since she has been a resident of the facility. When R1 was asked if she remembered going to the hospital, she said yes and that the hospital checked her out and sent her to the facility. R1 did not remember where she was picked up. R1 did not remember speaking with a police officer nor did R1 remember where she slept the night prior. The facility's Elopement and Wandering Residents Policy revised September 5, 2025, shows, "This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement received adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering	S9999					

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S9999	Continued from page 6 or elopement risk. The facility is equipped with door locks/alarms to help avoid elopements. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. Adequate supervision will be provided to help prevent accident or elopements." (A)	S9999					