(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING.				
		IL6016059	B. WING		06/2	8/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
SMITH C	SMITH CROSSING 10501 EMILIE LANE ORLAND PARK, IL 60467						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	ON SHOULD BE COMPLÉT E APPROPRIATE DATE		
S 000	Initial Comments		S 000				
	Annual Licensure S	Survey					
S9999	Final Observations		S9999				
	Statement of Licensure Violations:						
	300.615e)						
		etermination of Need uest for Resident Criminal rmation					
	Section 2-201.5(a) facility shall, within resident, request a check pursuant to t Information Act for admission to the facheck was initiated Hospital Licensing be based on the resand other identifiers	e screening required by of the Act and this Section, a 24 hours after admission of a criminal history background he Uniform Conviction all persons 18 or older seeking cility, unless a background by a hospital pursuant to the Act. Background checks shall sident's name, date of birth, as required by the e Police. (Section 2-201.5(b)					
	This requirement w	as NOT met as evidenced by:					
	failed to do residen hours on the CHIRI Response Process	and record review, the facility the background checks within 24 (Criminal History Information) and submit proof of the dates epartment of Corrections was					
		5 residents (R117, R218, 421) in sample of 20.					

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 07/16/24

TITLE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) DATE SURVEY COMPLETED	
		IL6016059	B. WING		06/2	8/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
SMITH C	SMITH CROSSING 10501 EMILIE LANE ORLAND PARK, IL 60467						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
S9999	Continued From pa	ge 1	S9999				
	Findings include:						
	6/24/24. R421's CH Sex Offender Regis facility did not provisure of the sex o	hen the Illinois Department of					

Illinois Department of Public Health

STATE FORM 6899 WHBY11 If continuation sheet 2 of 3

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
		IL6016059	B. WING		06/2	8/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
SMITH C	SMITH CROSSING 10501 EMILIE LANE ORLAND PARK, IL 60467						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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)	LD BE	(X5) COMPLETE DATE	
S9999	needed to be done to the facility. V31 s complete the backg of admission. The facility policy At November 2023 state background must be offender registry sharesident admitting to follow their protocol admission. If the reformeder, then the pwithout a departme evaluation. The facility did not possible to the facility did not pos	within 24 hours of admission stated they usually try to ground checks within 48 hours dmission of a Resident dated	S9999				

6899

Illinois Department of Public Health STATE FORM

WHBY11 If continuation sheet 3 of 3