STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016059	A. BUILDING: _____ B. WING _____	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)5) 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.	S9999		

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S9999	Continued From page 1	S9999		

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:

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

These regulations were not met as evidenced by:

Based on observation, interview, and record review, the facility failed to prevent the development of an unstageable pressure ulcer for a resident at moderate risk for skin breakdown. This failure led to a resident requiring skin grafting.

This applies to 1 of 4 residents (R59) reviewed for pressure ulcers in a sample of 21.

The findings include:

On 06/17/25 at 10:14 AM, a bright-red, quarter-sized, open wound was present on R59's sacrum. R59 had an indwelling urinary catheter.

R59's electronic health records showed that he was admitted on 12/15/24, with R59's first pressure ulcer risk assessment completed on 3/4/2025. The assessment showed R59 was at

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moderate risk for skin breakdown.

On 06/17/25 at 10:14 AM, V27 (Wound Nurse) stated that R59 had a stage 4 pressure ulcer. V27 said that R59's stage 4 pressure ulcer started as MASD (Moisture Associated Skin Damage) to R59's sacrum and the MASD could have been avoided by providing incontinence care and frequent repositioning. V7 provided R59's sacral wound measurement note titled "Skilled March 2025" that showed the pressure ulcer was 3.0 x 2.0 x 0.1 (in centimeters-cm) and staged at unstageable, and it was acquired at the facility. The note showed the MASD area with the pressure ulcer was identified on 2/4/25. V7 said that as the MASD to R59's sacrum was being treated, the Wound Doctor determined an area of the MASD was actually a stage 2 pressure ulcer. V27 stated the stage 2 pressure wound then progressed to a stage 4 pressure wound. R59's 3/6/25 wound physician notes showed the sacrum wound was unstageable due to necrosis, and the size of the wound was 3 x 2 x 0.1 cm, with 60% necrotic tissue. V7 said that the 3/6/25 wound note was the initial measurement for R59's sacral pressure wound. R59's 6/12/25 wound physician notes showed the sacrum wound had progressed to as stage 4. The same note showed "Skin Substitute Application Note: During today's visit this full thickness, chronic stage 4 pressure wound sacrum wound underwent the placement of a skin substitute graft..."

On 06/15/25 at 12:36 PM, R59 acknowleged he had a pressure wound. On 06/17/25 at 01:33 PM, R59 said that he got the wound to his sacrum from being in his bed and chair. R59 said that staff only reposition him two or three times a day and that he is incontinent of stool. R59 said

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that he just waits until the staff come to change him. R59's 5/28/25 MDS (Minimum Data Set) shows that R59's cognition is intact.

On 06/17/25 at 01:46 PM, V28 CNA (Certified Nurse's Assistant) stated she is familiar with R59 and his stool is soft most of the time, and when she comes in in the morning, she finds R59 incontinent of stool most of the time.

On 06/17/25 at 01:05 PM, V18 (Wound Physician) said that R59's pressure ulcer would have been avoidable with proper incontinence care and repositioning. V18 said that she had to provide R59 with substitute skin grafting because R59's wound healing was delayed.

R59's 5/28/2025 MDS showed he was dependent on staff for toileting hygeine, and rolling over from left to right in bed. R59's bowel incontinence care plan (revised 2/14/25) showed he was at risk for impaired skin integrity. The interventions included to check R59 every two hours and assist with toileting as needed and provide peri care after each incontinent episode. R59's stage 4 pressure ulcer care plan (initiated 3/4/2025) identified risk factors of bowel incontinence, poor mobility, aging fagile skin, and muscle wasting. Interventions showed "Turn and reposition every two hours and as needed." R59's June 2025 physician's orders showed an order from 2/12/25 "Turn and reposition every 2 hours and as needed."

On 06/17/25 at 02:25 PM V2 DON (Director of Nursing) said that staff are to follow the physician orders, reposition every 2 hours, and do frequent rounds to check to see if the residents are soiled or not. V2 said that staff should do more frequent checks if the resident is incontinent of stool and

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S9999	Continued From page 4 does not let staff know. V2 said that the facility should educate the staff and resident to ensure frequent rounding is being done and to inform the resident to notify staff when he needs changing. V2 said staff should keep the resident's skin dry, change residents frequently, and frequently reposition residents. The facility did not provide a policy for prevention of pressure wounds. (A)	S9999		