STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145904	A. Building B. Wing	05/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smith Village	2320 West 113th Place Chicago, IL 60643

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the physician and residents' representatives when new treatments were initiated and failed to notify the physician of abnormal laboratory results for three (R1, R2 and R3) of three residents reviewed for notification of changes. This deficient practice had the potential to delay medical evaluation and treatment, limit resident and representative participation in care planning and informed decision-making, and place residents at risk for worsening conditions, avoidable hospitalization, and adverse health outcomes. R1 was admitted to the facility on [DATE] and discharged home on 2/18/2026. Her medical history includes fracture of left pubis, acute kidney failure, muscle wasting and atrophy, ataxic gait, type 2 diabetes mellitus, elevated white blood cell count, dementia, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, hyperlipidemia and essential (Primary) hypertension. R1's Physician Order Sheet documents an order dated 2/11/2026 as follows: Ciprofloxacin HCl 500 MG Tablet 1 tablet by mouth twice daily for 7 days until finished (Dx: (Diagnosis) UTI (Urinary Tract Infection)) Review of R1's progress notes exclude any documentation that R1's family member was informed that antibiotics were started for R1. R1?s laboratory results with a report date of 2/16/2026 13:37 showed the following abnormal results: BUN 26 mg/dLBlood Urea Nitrogen measures the amount of urea nitrogen (another protein-waste product) in your blood. The normal range is generally 7 to 223 mg/dL. Creatinine 2.1 mg/dLCreatinine is a waste product naturally produced by muscles and filtered out by healthy kidneys. Normal levels generally range from 0.4 to 1.6 mg/dL. EGFR (Non African American) 21mL/min.The Estimated Glomerular Filtration Rate measures how well your kidneys filter blood. A normal eGFR is 60 or above. V1, Director of Nursing (DON) presented a copy of R1's laboratory results with notation stating the results were sent to V9, R1's physician, on 2/17/2026 12:20 P.M. However, interview with V9 indicated that he was not made aware of the abnormal laboratory results. V1 is also unable to verify if the results were sent via fax or via telephone conversation or via text. On 5/16/2026 at 11:30 A.M., V9, R1's Physician, stated V9 was not aware that R1 ended up in the hospital after being discharged from the facility. V9 stated the abnormal laboratory results taken on 2/16/2026 were not relayed to him. V9 also stated that although he cannot keep residents in the facility for medical reasons once physical therapy says that R1 is ready for discharge, V9 would have given R1 a bag of intravenous fluids, instructed R1 to increase fluids and then follow up with her primary care physician for follow up and monitoring because of R1's abnormal results which could indicate dehydration. R2's Physician Order Sheet documents an order dated 2/13/2026 as follows:Ciprofloxacin HCl 500 MG Tablet 1 tablet by mouth twice daily for 7 days (Dx: (Diagnosis) UTI (Urinary Tract Infection)) Review of R2's progress notes exclude any documentation that R2's family member was informed that antibiotics were started for R2. R3's Physician Order Sheet documents an order dated 2/13/2026 as follows: Ertapenem Sodium Injection Solution Reconstituted 1 GM (Ertapenem Sodium) Use 1 gram intravenously at bedtime for UTI for 7 Days Review of R3's progress notes exclude any documentation that R3's representative was informed that antibiotics were started for R3. On 5/15/2026 at 2:05 P.M., V1, Director of Nursing, stated family should be notified by phone (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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	145904	A. Building B. Wing	05/16/2026

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	or in person and documentation of family notification should be found on the progress notes. V1 stated he did not see documentation in R1 and R2's progress notes that their representatives were notified of starting antibiotics for R1 and R2. V1 presented the facility policy titled Notification of Changes with date reviewed/revised July 2025 which states: The facility must inform the resident, consult with the resident's physician and notify the resident's family member or legal representative when there is a change requiring such notification. The policy includes starting a new treatment as one of the circumstances requiring notification.

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	145904	A. Building B. Wing	05/16/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an appropriate discharge for one resident reviewed for discharge practices by discharging the resident despite abnormal laboratory results indicative of dehydration. This deficient practice affected one (R1) of two residents reviewed for discharge. As a result, R1 was readmitted to the hospital within 48 hours of discharge with diagnoses of acute metabolic encephalopathy, likely secondary to a combination of dementia, dehydration, and urinary tract infection (UTI).Failure to ensure the resident was medically stable prior to discharge had the potential to result in worsening dehydration, delayed medical treatment, increased risk for hospitalization, and adverse health outcomes related to unresolved clinical conditions.R1 was admitted to the facility on [DATE] and discharged home on 2/18/2026. Her medical history includes fracture of left pubis, acute kidney failure, muscle wasting and atrophy, ataxic gait, type 2 diabetes mellitus, elevated white blood cell count, dementia, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, hyperlipidemia and essential (Primary) hypertension.R1?s laboratory results with a report date of 2/16/2026 13:37 showed the following abnormal results:BUN 26 mg/dLBlood Urea Nitrogen measures the amount of urea nitrogen (another protein-waste product) in your blood. The normal range is generally 7 to 223 mg/dL.Creatinine 2.1 mg/dLCreatinine is a waste product naturally produced by muscles and filtered out by healthy kidneys. Normal levels generally range from 0.4 to 1.6 mg/dL.EGFR (Non African American) 21mL/min.The Estimated Glomerular Filtration Rate measures how well your kidneys filter blood. A normal eGFR is 60 or above.V1, Director of Nursing (DON) presented a copy of R1's laboratory results with notation stating the results were sent to V9, R1's physician, on 2/17/2026 12:20 P.M. However, interview with V9 indicated that he was not made aware of the abnormal laboratory results. V1 is also unable to verify if the results were sent via fax or via telephone conversation or via text. On 5/16/2026 at 11:30 A.M., V9, R1's Physician, stated V9 was not aware that R1 ended up in the hospital after being discharged from the facility. V9 stated the abnormal laboratory results taken on 2/16/2026 were not relayed to him. V9 also stated that although he cannot keep residents in the facility for medical reasons once physical therapy says that R1 is ready for discharge, before discharging R1, V9 would have given R1 a bag of intravenous fluids, instructed R1 to increase fluids and then follow up with her primary care physician for follow up and monitoring because of R1's abnormal results which could indicate dehydration.On 5/15/2026 at 3:34 P.M., V10, receiving home health agency Director of Nursing, stated R1's start of care with the agency was 2/19/2026 and R1 went back to the hospital within 24 hours of start of care on 2/20/2026 with a diagnosis of acute metabolic encephalopathy most probably combination of dementia, dehydration and urinary tract infection. V10 also stated the abnormal laboratory results drawn on 2/16/2026 were not provided by the facility to their home health agency. V10 acknowledged receiving R1's Discharge Summary and that they expect to receive any laboratory results that would require monitoring and follow-up to be provided as well by the transferring facility. V10 also stated that R1's abnormal lab results do not surprise V10 because R1 already had a diagnosis of Acute Kidney Failure and will not impact R1's start of care. R1's Hospital records under assessment and plan dated 2/21/2026 documents under Assessment and Plan: Acute metabolic encepalopathy most probably combination of dementia and (sic) dehydration and UTI (Urinary Tract Infection).Facility policy titled Transfer and Discharge (including AMA) with date reviewed/revised 5/26 documents: It is the policy of the facility to permit each resident to remain in the facility and not transfer or discharge the resident from the facility, except in limited circumstances.