STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146110	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smith Crossing	10501 Emilie Lane Orland Park, IL 60467

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 45395 Based on interviews and record review, the facility failed to recognize an injury of unknown origin as a suspected allegation of abuse and failed to report an allegation of abuse to the administrator. This failure applies to 1 of 1 resident (R2) reviewed for abuse in a sample of 4. Findings include: R2's face sheet showed an initial admitted on 07/12/2021 with a past medical history not limited to: left humerus fracture (04/18/2025), dementia, spinal stenosis, heart failure, type 2 diabetes, hypertension and transient ischemic attack and cerebral infarction. Undated final incident report documented that on 04/15/2025, R2 was noted to be guarding her left arm. Resident then noted complaining of pain when staff went to touch her hand and straighten her clothing. Medication administered for pain and order for x-ray to hand and arm obtained. While awaiting diagnostic company, resident noted with emesis and was sent to emergency room (ER) via emergency medical services (911) per power of attorney. While in hospital, x-ray obtained to left arm with findings of comminuted and impacted fracture involving the left humeral head. Resident was admitted to the hospital. R2's diagnostic radiology results dated 04/16/2025 showed findings of comminuted fracture and impacted involving the left humeral head. Hospital records diagnostic report electronically signed by V14 (Medical Doctor) documented under findings and impressions that R2 has comminuted and impacted fracture involving the left humeral head. On 04/29/2025 at 11:19 AM, V4 (Certified Nursing Assistant) said at approximately 06:45 AM on the morning of 04/15/2025, while V4 was trying to put a shirt on R2, she had started screaming when V4 touched R2's left hand. V4 (Certified Nursing Assistant) then indicated that R2's arm was floppy and was loose and extended when R2's arm is normally restricted and held tight to her body. V4 said she did not get anything in report about R2's arm. V4 added that she saw a green colored bruise to R2's left upper arm and said she didn't know of R2 having any recent falls. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/29/2025 at 2:33 PM, V10 (Licensed Practical Nurse) said on 04/12/2025 during lunch, she was at her med cart when R2 yelled out in pain. V13 (Family Member) was present and said she thinks the pain is to her left arm then proceeded to tell V10 that she (V13) had seen two agency staff on the camera that morning that seemed a little rougher than normal when getting [R2] ready and out of bed. When asked if she reported to the manager on duty what V13 (Family Member) saw on the camera that morning, V10 (Licensed Practical Nurse) said she didn't tell anyone because based on how V13 communicated it to her, V10 didn't think it was done maliciously. On 04/302025 at 02:12 PM, V13 (Family Member) said there is a camera in R2's room and on the morning of 04/12/2025, she watched two agency aides (V7, V8) come into the room and transfer R2 onto a shower chair then take her out of the room. V13 (Family Member) said when they returned to R2's room, they put her back into bed then proceeded to turn her from side to side while dressing R2. V13 said at one point, she saw the aides had grabbed onto R2's contracted left arm and her left thigh then proceeded to pull on her arm and thigh to turn R2 onto her right side. V13 said at that time, R2 yelled out and said they hurt her arm. V13 (Family Member) said when she came at lunch time, R2 was complaining that her arm was hurting so she had asked the nurse (V10) to give R2 pain medicine. V13 then said she informed V10 (Licensed Practical Nurse) of what was seen on the camera that morning and how they had pulled on her left arm and V10 (LPN) proceeded to say to V13, oh no they shouldn't have done that. V13 (Family Member) said she showed the Director and Assistant Director of Nursing, another nursing supervisor and several other staff the video and pictures from the incident on 04/12/2025 and was told by them all that, they should not have ever pulled her arm to turn her, they should always use a lift shift or place their arms on her thighs and back of shoulder. On 04/30/2025 at 02:45 PM, prior to conducting exit conference with V1 (Administrator), V2 (Director of Clinical Operations) and V3 (Assistant Director of Nursing), surveyor asked V1 if she was informed of V13's (Family Member) concerns regarding what she saw on the camera on 04/12/2025 and whether there was a suspicion of abuse. V1 said she was on leave when this incident occurred, and V3 said she was made aware on the 15th, of the incident which was not viewed as abuse. At 02:50 PM, when asked if V10 (Licensed Practical Nurse) had informed V1, V2, or V3 of V13's (Family Member) statement that two agency staff were seen on camera and seemed a little rougher than normal when getting R2 ready and out of bed, V3 (Assistant Director of Nursing) said R2's incident would have been investigated as abuse. Injury of Unknown Origin/Unexplained Injuries last reviewed/revised in August 2024 reads in part: Reporting and investigation procedures shall be implemented in accordance with the facility's abuse policies and procedures. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Abuse, Neglect and Exploitation policy last reviewed/revised on 08/26/2024 reads in part: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property .Alleged Violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property .Mistreatment means inappropriate treatment or exploitation of a resident .The facility will develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property .Include training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriate of resident property, reporting procedures, and dementia management and resident abuse prevention .The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45395 Based on interviews and record review, the facility failed to ensure that a cognitively impaired resident received treatment and care in accordance with professional standards of practice for 1 of 4 residents (R2) reviewed for nursing care and services. This failure resulted in staff pulling on R2's contracted arm while turning resident in bed that caused R2 to experience moderate to severe pain to her left arm and was subsequently diagnosed with a fracture to the left humeral head (upper arm). Findings include: R2's face sheet showed an initial admitted on 07/12/2021 with a past medical history not limited to: left humerus fracture (04/18/2025), dementia, spinal stenosis, heart failure, type 2 diabetes, hypertension and transient ischemic attack and cerebral infarction. R2's Minimum Data Set (MDS) dated [DATE] under Section C for cognitive patterns showed a Brief Interview for Mental Status (BIMS) score of 02/15 that indicates severe cognitive impairment. Section GG documented under functional limitation in range of motion, upper extremity impairment to one side and R2 is dependent on staff for showering/bathing, dressing, rolling side to side and for transfers. R2's care plan documented communication problem related to hearing and dementia and impaired visual function (last revised 11/12/2024); possible contracture to left elbow requiring splint/brace that is not worn due to not being tolerated, non-weight bearing to left upper extremity due to humerus fracture, sling to be worn at all times (last revised on 04/25/2025); acute pain related to fracture of the left humerus (last revised 04/29/2025). Undated final incident report documented that on 04/15/2025, R2 was noted to be guarding her left arm. Resident then noted complaining of pain when staff went to touch her hand and straighten her clothing. Medication administered for pain and order for x-ray to hand and arm obtained. While awaiting diagnostic company, resident noted with emesis and was sent to emergency room (ER) via emergency medical services (911) per power of attorney. While in hospital, x-ray obtained to left arm with findings of comminuted and impacted fracture involving the left humeral head. Resident was admitted to the hospital. R2's diagnostic radiology results dated 04/16/2025 showed findings of comminuted fracture and impacted involving the left humeral head. Hospital records diagnostic report electronically signed by V14 (Medical Doctor) on 04/16/2025 documented under findings and impressions that R2 has comminuted and impacted fracture involving the left humeral head. R2's active orders as of 04/29/2025 showed orders not limited to non-weight bearing to left upper extremity, follow-up ortho appointments as needed, sling to left arm to be worn at all times. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 04/29/2025 at 10:42 AM, R2 was observed in activity/dining area near her unit resting in her reclining chair with upper body covered with a blanket. R2 was alert to self but was not interviewable. On 04/29/2025 at 11:19 AM, V4 (Certified Nursing Assistant/CNA) said at approximately 06:45 AM on the morning of 04/15/2025, while V4 was trying to put a shirt on R2, she had started screaming when V4 touched R2's left hand. V4 (CNA) then indicated that R2's arm was floppy and was loose and extended when R2's arm is normally restricted and held tight to her body. V4 said she did not get anything in report about R2's arm. When asked what she did when R2 started screaming, V4 (CNA) said she stopped what she was doing and went to tell the nurse then finished dressing R2. V4 added that she saw a green colored bruise to R2's left upper arm and said she didn't know of R2 having any recent falls. On 04/29/2025 at 12:25 PM, called V8 (Medical Director) who said that R2 is an elderly patient with a history of dementia, cerebrovascular accident, chronic kidney disease, diabetes, chronic constipation and bilateral inguinal hernia. V8 (Medical Director) said that she suspects that R2 has osteoporosis and bone degeneration, but she can't confirm this without having bone density medical imaging tests done. V8 then said that R2's family doesn't want to do any surgical interventions due to the high risk of complications. V8 (Medical Director) said she had ordered an x-ray be done of R2's shoulder but resident was sent out due to other medical issues, so she was x-rayed at the hospital and that's when the fracture to her left arm was found. V8 (Medical Director) added that she cannot say exactly that the fracture happened during normal positioning or movement but is possible. It's also possible that is a pathological fracture due to her history but can't be confirmed without testing. On 04/29/2025 at 12:50 PM, V6 (Restorative Aide) said on 04/15/25 during breakfast, she placed a clothing protector on R2 and when she straightened it out, V6 had lightly touched R2's left forearm and then R2 yelled out in pain and she went and told her nurse. V6 added that she didn't notice any injury or swelling because she was fully covered by a blanket. She said that R2 always favored her left arm which is slightly contracted. V6 added that R2 is in the restorative program, and she usually sees R2 daily to perform range of motion on her bilateral upper extremities but performs less to her contracted arm. V6 then said most of the time she can stretch out R2's arm some, she is a feeder, and needs to be dressed by staff. On 04/29/2025 at 12:58 PM, V7 (Agency Aide) said she was assigned to R2 on 04/12/25. V7 said she showered R2 in the shower room then dressed her in her room with the assistance of another agency aide (V8). V7 has never worked with this aide prior. V7 has cared for R2 with facility staff previously. V7 said that she didn't notice any injury to R2's arm. V7 (Agency Aide) added that R2 normally moans when touched, and she didn't see or hear anything out of the ordinary. V7 also said that one of her arms is always close to her upper body area and she could move the other arm. V7 said R2 did not complain of pain, she had no facial grimacing. V7 (Agency Aide) then said staff told her previously that R2 doesn't like to be touched and that when she was being rolled side to side, she was making random noises that sounded like she was trying to talk. She added that R2 was making those same noises during her shower and while they were dressing her, but it did not sound like she was in pain. V7 (Agency Aide) then said someone told her it looked like the other aide pulled R2's arm when she was being rolled side to side on the video but V7 (Agency Aide) didn't recall seeing the other agency aide (V8) pulling on R2's arm. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 04/29/2025 at 01:18 PM, V8 (Agency Aide) said V7 (Agency Aide) had asked for her help with R2, so she assisted V7 transfer R2 into a shower chair with a mechanical lift. V8 said after the shower, they brought R2 back to her room and transferred her back into the bed with mechanical lift. V8 then said they dried R2's body then proceeded to roll her from side to side to get her dressed. V8 said her hands were on R2's shoulder and legs, and it did not look like R2 was in pain. V8 (Agency Aide) then said she was told by a staff member that R2's family saw her pulling on R2's arm but it looked aggressive. V8 said she worked with R2 a few times on second shift and was unaware of any limitations other than one of her arms being held close to her body. V8 (Agency Aide) didn't recall pulling on R2's arm when she was assisting V7 (Agency Aide). V8 said she was called into the office on 04/17/025 and was interviewed then in-serviced on bed mobility and positioning. On 04/29/2025 at 2:33 PM, V10 (Licensed Practical Nurse) said on 04/12/2025 during lunch, she was at her med cart when R2 yelled out in pain. V13 (Family Member) was present and said she thinks the pain is to her left arm. V10 (LPN) said R2's left arm was contracted per her baseline and there was no visible injury noted. V10 added that R2 normally screams when you touch her but when she assessed her left arm at that time, R2 didn't scream out like she normally would. V10 (Licensed Practical Nurse) proceeded to say that V13 (Family Member) told her she saw two agency staff on the camera this morning that seemed a little rougher than normal when getting [R2] ready and out of bed. V10 (Licensed Practical Nurse) said R2 had screamed when she administered her the pain medication. She added R2 had no further complaint of pain for the remainder of shift. When asked if she reported to the manager on duty what V13 (Family Member) saw on the camera that morning, V10 (Licensed Practical Nurse) said she didn't tell anyone because based on how V13 communicated it to her, V10 didn't think it was done maliciously. V10 (Licensed Practical Nurse) said she did talk to the aides (V7, V8) about what V13 (Family Member) had said and was then informed by V7 & V8 (Certified Nursing Assistants) that R2 was screaming the whole time during cares. On 04/302025 at 02:12 PM, V13 (Family Member) said there is a camera in R2's room and on the morning of 04/12/2025, she watched two agency aides (V7, V8) come into the room and transfer R2 onto a shower chair then take her out of the room. V13 (Family Member) said when they returned to R2's room, they put her back into bed then proceeded to turn her from side to side while dressing R2. V13 said at one point, she saw the aides had grabbed onto R2's contracted left arm and her left thigh then proceeded to pull on her arm and thigh to turn R2 onto her right side. V13 said at that time, R2 yelled out and said they hurt her arm. V13 then said the aides put R2 onto her back and continued to get her dressed, then picked up both arms to put deodorant on and put her arms into the sleeves of her shirt. V13 (Family Member) added that during the time these aides were getting R2 dressed, R2 was saying her arm hurt. After R2 was dressed, V7 and V8 (Agency Aides) transferred R2 into her chair, and R2 was still complaining of arm pain at that time. V13 (Family Member) said when she came at lunch time, R2 was complaining that her arm was hurting so she had asked the nurse (V10) to give R2 pain medicine. V13 then said she informed V10 (Licensed Practical Nurse) of what was seen on the camera that morning and how they had pulled on her left arm and V10 (LPN) proceeded to say to V13, oh no they shouldn't have done that. V13 (Family Member) said on the morning of 04/15/25, the facility informed her that R2 was complaining of pain to her left arm and were awaiting portable x-rays to be done. V13 added that R2 was sent to the emergency room for another medical issue and was x-rayed at the hospital which showed a fracture to R2's left arm. V13 (Family Member) said she showed the Director and Assistant Director of Nursing, another nursing supervisor and several other staff the video and pictures from the incident on 04/12/2025 and was told by them all that, they should not have ever pulled her arm to turn her, they should always use a lift shift or place their arms on her thighs and back of shoulder. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of facility in-service on 04/17/2025 showed nursing staff were educated on bed mobility/positioning, use of draw, do not pull on [patient's limbs], position hands behind shoulder and the knee. V7 and V8 (Agency Aides) both signed the in-service log. Injury of Unknown Origin/Unexplained Injuries last reviewed/revised in August 2024 reads in part: to provide guidance to staff and a standard protocol for investigating and reporting injuries of unknown origin .Reporting and investigation procedures shall be implemented in accordance with the facility's abuse policies and procedures.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45395 Based on observation, interviews, and record review, the facility failed to implement effective fall interventions to minimize the risk of falls, failed to ensure current fall interventions were in place for a resident at risk for falls, and failed to provide adequate supervision to prevent repeated falls with or without significant injury for 3 of 4 residents (R1, R3, R4) reviewed for accidents and supervision in a sample size of 4. This failure resulted in R4, who is a high fall risk with repeated falls, being observed without current fall preventative interventions in place; and resulted in R1 and R3 who had repeated falls and subsequently were emergently transferred to the hospital after a fall incident for treatment of a cervical neck fracture and facial abrasion (R1) and closure of a head laceration with staples (R3). Findings include: Review of facility fall log for [DATE] and February through [DATE] showed the following: R1: with fall incidents on [DATE], [DATE] and [DATE]. R3 with fall incidents on [DATE], [DATE] and [DATE]. R4 with fall incidents on [DATE], [DATE] and [DATE]. 1. R1's face sheet showed admitted [DATE] with a past medical history not limited to: falls, head injury, urinary tract infection, muscle wasting and atrophy, fracture of first cervical vertebrae, osteoarthritis, degenerative disease of nervous system, dementia, age-related osteoporosis, abrasion to part of the head, confusional arousals (mental confusion after awakened), disorientation, weakness, and dizziness and giddiness and palliative care. Face sheet indicated R1 discharged on [DATE] (expired). Care plan with effective date of [DATE] documented R1 was at risk for injury related to fall risk with interventions not limited to floor mats to bedside, staff to provide safety checks to ensure resident's needs are met and to assist with toileting between ,d+[DATE] AM, monitor frequently to ensure needs are met ([DATE]), ensure phone and other items are within reach ([DATE]), bed/chair alarm to alert staff to postural changes, keep resident in public areas as much as possible for increased supervision, keep bed in lowest position when in bed. R1's active physician orders for [DATE] showed orders not limited to admit to hospice ([DATE]) for chronic obstructive pulmonary disease, high fall risk-ensure all fall precautions are in place ([DATE]), wear neck collar at all times except while bathing for 3 months. R1's Minimum Data Set (MDS) dated [DATE] under Section C for cognitive patterns showed a Brief Interview for Mental Status (BIMS) score of ,d+[DATE] that indicated no cognitive impairment. Section GG documented under functional limitation in range of motion, lower extremity impairment to both sides and that R1 was dependent on staff for toileting hygiene, showering/bathing, rolling side to side, and for transfers. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's fall risk assessment dated [DATE] documented score of 16. Assessment indicated overall score of 10 or above represents high risk. Clinical note report and fall risk assessment both documented R1 had a fall on [DATE] at 4:45 AM where she was observed on floor in her room laying on the mat. R1 was again observed on the floor mat next to the bed lying on her right side and facing the bathroom on [DATE], and on [DATE] at 02:58 PM, R1 was found on the floor on the right side of her bed. R1 stated she hit her head and was noted with a skin tear to the right side of her head and an abrasion/skin tear to the left cheek. R1 was transferred emergently to the local hospital for evaluation and was admitted with a cervical neck fracture. R1's hospital paperwork dated [DATE] at 04:48 PM (16:48) documented under discharge diagnosis, C1 cervical fracture; Dementia; Fall; Low back pain. Documented under additional discharge instructions were orders to cleanse left cheek abrasion with wound cleanser and apply [petroleum jelly] gauze and cover with 4x4 [dressing] daily. On [DATE] at 09:07 AM, V3 (Assistant Director of Nursing/ADON) said R1 was a fall risk then proceeded to say that R1 had a fall on [DATE] at 4:45 AM where she was observed on the floor in her room laying on a floor mat. V3 added that R1 was on an antibiotic for urinary tract infection at that time and was confused and that R1 fell while trying to get the call light from the room across the hall. V3 (ADON) said R1 had another fall on [DATE] at 7:55 PM where she was observed on floor in her room laying on mat. V3 said R1 was trying to get to the phone to call her daughter. Review of care plan with V3 showed no new interventions were implemented, previous intervention of keeping personal items within reach was reworded to include R1's phone. V3 (ADON) then said R1 fell again on [DATE] at 2:58 PM where she was observed on the floor in her room on the side of bed. R1 indicated that she was trying to go to the bathroom. V3 added that R1 sustained a laceration to her head, an abrasion to her cheek, and was sent to emergency room and was admitted with first cervical vertebra fracture. V3 (ADON) said that R1 had fall mats in place but thicker mats were placed after the [DATE] due to her history of attempting to self-transfer which led to the falls. V3 added that on [DATE], R1 was last rounded on at 2:00 PM and V12 (Previous Supervisor) and V11 (Activity Director) were the first staff members to respond to the fall on [DATE]. V3 (Assistant Director of Nursing) added that R1 returned to the facility, was started on hospice for chronic obstrutive pulmonary disease then expired days later. On [DATE] at 09:38 AM, V11 (Activity Director) said on [DATE], she was in her office which was across from R1's room on the skilled unit when she heard a loud thumping noise. V11 said when she got to the room, R1 was laying on her side between the side of the bed and a recliner and stated she was trying to go the bathroom. V11 didn't recall seeing any injuries. V11 (Activity Director) added that V12 (Previous Nursing Supervisor) was doing her rounds and happened to arrive after her and came in the room to assess R1. On [DATE] at 10:00 AM, attempted to call V12 (Previous Nursing Supervisor) regarding R1's fall on [DATE]. Phone number is no longer in service. 2. R3's face sheet showed initial admitted on [DATE] with a past medical history not limited to: laceration to head ([DATE]), dementia/vascular dementia with anxiety, osteoarthritis, cognitive communication deficit, weakness, depression, history of fall, left femur fracture and urinary tract infection. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R3's care plan with date initiated of [DATE] indicated that R3 is risk for falls due to her personal history of falls which resulted in right hip fracture, weakness, cognitive deficits and limited mobility manifested by her attempts to get up from bed unassisted, attempts to self-transfer to toilet without assistance and attempting to get up from wheelchair without assistance and fell to the floor causing head injury (subdural hematoma) and attempted to self-propel in wheelchair and fell with last revision date of [DATE]. Care plan interventions for R3 included but are not limited to: [DATE]-when sitting in the wheelchair, ensure wheelchair is not locked so resident can self-propel. Provide education on use of wheelchair brakes with resident; [DATE]-keep resident out of room and engaged in the evening due to increased confusion during the evening hours; [DATE]-staff encouraged to keep resident's room door closed while out of room; [DATE]-monitor resident often while in room to decrease risk of falls and/or injuries; [DATE]-staff to provide incontinence care every 2 hours throughout the day/night to help decrease risk of falls and/or injuries. 9-, d+[DATE]-Virtual Sense Technology (VST) alert monitoring ordered to be put in place; ensure bed is kept in lowest position, yellow star on door frame to indicate a high risk for falls; floor mats at bedside when resident is in the bed; requires extensive to total assistance with activities of daily living last revised on [DATE]. R3's fall note (day 1) dated [DATE] at 07:16 PM documented R3 was not observed in common area; was observed in her room on the floor lying on her right side next to the wheelchair and near the closed bathroom door. R3's fall note (day 1) dated [DATE] at 05:15 PM documented during rounding, resident was observed sitting on buttocks between her wheelchair and the bed .R3 on quarantine and is to stay in room with monitoring by staff. Certified Nursing Assistant (CNA) rounding every 30 minutes for resident safety . R3's fall note (day 1) dated [DATE] 10:12 PM documented R3 was observed sitting on the side of the bed on the floor and was bleeding from a laceration to her head. Emergency services (911) were called and R3 was emergently transferred to the local hospital. R3's fall risk evaluation dated [DATE] indicated R3 is at risk for falls with intervention to initiate frequent neuro checks and bleeding evaluation per facility protocol if an injury occurs. R3 care plan with date initiated of [DATE] documented R3 is at risk for falls with interventions not limited to initiate frequent neuro checks and bleeding evaluation per facility protocol if an injury occurs. Undated final incident report documented on [DATE] that R3 was observed on the floor with her head against the bed and was noted with bleeding to her scalp. R3 was transferred emergently to local hospital for further evaluation. R3 returned to facility with four staples to her head. R3's fall note (day 2) dated [DATE] 06:36 AM documented that R3 returned from hospital at 12:50 AM accompanied by her daughter .Resident sent out to emergency department by evening shift nurse due to laceration to the head related to a fall .Noted 4 staples to right side of R3's head that was open to air .Order in place to remove staples in ,d+[DATE]days .Re-educated on call light use and fall precautions - resident verbalized understanding . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146110	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smith Crossing	10501 Emilie Lane Orland Park, IL 60467

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Health Status Note dated [DATE] 08:09 PM documented post emergency room (ER) visit follow-up. R3 fell and was sent to ER for evaluation. She had parietal scalp laceration wound which was stapled .Discussed with nurse, may remove staples in one week. Health Status Note dated [DATE] at 09:18 PM documented new order per V9 (Medical Director) to remove staples from R3's head per hospital discharge instructions from ER within ,d+[DATE] days from [DATE]. R3's Minimum Data Set (MDS) dated [DATE] under Section C for cognitive patterns showed a Brief Interview for Mental Status (BIMS) score of ,d+[DATE] for R3 that indicates severe cognitive impairment. Section GG documented under functional limitation in range of motion, lower extremity impairment to one side and R3 requires substantial/maximal assistance from staff for toileting, showering/bathing, upper body dressing, dependent for lower body dressing, and moderate assistance with rolling side to side, transfers and ambulating 10 feet or less. On [DATE] at 10:40 AM, R3 was observed in the activity/dining area near her unit seated in her wheelchair and engaged in activities. At 10:43 AM, upon approaching R3's room door, noted a yellow star hung near name placard and observed a thin gray mat between R3's bed and window and a second, thicker blue mat folded up under the head of the bed. On [DATE] at 11:28 AM, V5 (Licensed Practical Nurse) showed surveyor the VST monitor above R3's television and indicated that an alert sounds when resident tries to get out of bed. At 11:39 AM, R3 was observed at a table in the dining area off of unit seated in her wheelchair. R3 was alert to self but was not interviewable at this time. On [DATE] at 2:08 PM, called V11 (Agency Nurse) regarding R3's fall on [DATE]. No answer, detailed message left. On [DATE] at 2:10 PM, V12 (CNA) said on [DATE] after dinner, there was a lot of staff movement because they were trying to put residents in bed. V12 added that lots of residents are ready to lay down after dinner, and there's usually a staff member that stays with the residents in the activity/dining room area. V12 (CNA) said she had checked on R3 a few times in between residents and she was still in the activity/dining room area in her wheelchair. V12 said she was working a double shift that day and R3's unit wasn't her usual set, but she knew R3 was a high fall risk and had a few falls prior to this incident, so that's' why she wanted to check on her often. V12 (CNA) then said she was helping another resident in his room and when she came out of his room, V12 went to check on R3 but she was not in the activity/dining room area. V12 (CNA) said she found R3 in her room with her wheelchair was on the left side of the bed and R3 was on the right side of the bed near the window. V12 said R3 was on the floor and her head was bleeding so she got the nurse and the supervisor. V12 (CNA) added that most of the fall risk residents have virtual sense technology monitors (VST) and when it goes off, it will send an alert to a tablet that staff are always supposed to have with them. V12 indicated that she did not have a tablet with her, it was at the nurse's desk. V12 (CNA) then said the facility is very strict on falls and she should really have been fired but received a written warning instead because R3 had a fall with severe injury and the lack of supervision. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	3. R4's face sheet showed initial admitted on [DATE] with a past medical history not limited to: intervertebral disc degeneration, syncope and collapse, dementia, major depressive disorder, anxiety, need for assistance with personal care, fracture of lumbosacral spine and pelvis and right humerus, and fall. R4's Minimum Data Set (MDS) dated [DATE] under Section C for cognitive patterns showed a Brief Interview for Mental Status (BIMS) score of ,d+[DATE] for R4 that indicates moderate cognitive impairment. Section GG documented under functional abilities that R3 requires partial/moderate assistance with rolling side to side, sit to stand, with transfers and ambulating 10 feet or less. R4's fall note (day 1) dated [DATE] at 11:41 AM documented resident observed sitting on bathroom floor with back against wall at 0915 AM. R4's fall note (day 1) dated [DATE] at 12:23 AM documented resident was observed sitting on the floor at the foot of her bed .The resident was assisted to her [wheelchair] and was taken to the bathroom. Incontinent of small soft stool . R4's fall note (day 1) dated [DATE] at 11:52 AM documented, resident was noted sitting upright on buttocks against side of bed in her room. R4 stated she was trying to lay down. The brakes on R4's wheelchair were not activated . Facility provided incomplete fall risk evaluation for R4 dated [DATE] that does not indicate fall risk score, interventions or goals. R4's care plan documented impaired visual function without use of corrective lenses (last revised [DATE]); limited physical mobility related to decreased strength and endurance, muscle weakness and limited mobility (last revised [DATE]); risk for falls related to dementia, weakness and limited mobility and history of falls with no injury manifested by her attempts to get in bed without assistance (last revised [DATE]). R4's care plan interventions included but not limited to bed in lowest position, yellow star on door frame to indicate a high risk for falls, floor mats at bedside, last revised [DATE] (day surveyor entered). R4's active orders as of [DATE] showed orders not limited to bed in low position; close observation every shift-check hourly, toilet every 2 hours and as needed, personal necessitates and call light within easy reach; admit to hospice ([DATE]); safety-floor mats to be down when resident is in bed ([DATE]). On [DATE] at 10:46 AM, upon approaching R4's room door, noted a yellow star posted near outer doorframe and name placard. Surveyor then observed R4 sleeping in second bed (near the window) and was lying on her left side, facing the window. R4's lower legs (from shin down) were hanging off the side of the bed that was nearest the window. R4's bed was positioned at knee level and not at the lowest position or touching the floor. Surveyor noted a thin gray colored mat in place to the floor between R4's bed and the window. No other mats were observed in place. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 10:48 AM, V4 (CNA) was observed sitting at the desk area on unit. V4 indicated she has been employed at the facility for about a year and was last in-serviced on falls earlier in the month. V4 then said the posted yellow stars indicate those residents who are fall risks then said when residents at risk for falls are in bed, the bed should be to the ground with floor mats in place to both sides of the bed. V4 added that if fall risk resident is in their room, then staff check on them approximately every 15 minutes but do not document these frequent checks. V4 (CNA) did not indicate the last time she had last checked or toileted R4. V4 (CNA) then said that several fall risk residents have video surveillance (VST) in place which is a motion sensor monitor placed above the television that points towards the bed and alarms when the resident moves around. On [DATE] at 10:54 AM, upon approaching R4's room door, noted a yellow star hung near name placard and a sign posted next to doorframe that indicated video monitoring was in place. V4 (Certified Nursing Assistant) entered R4's room and indicted above the television where the VST monitor is normally placed. V4 the said that R4 had a monitor in place but she didn't know where the monitor was. On [DATE] at 11:25 AM, R4 was seated in her wheelchair near the bed in room resting with a wheeled tray table placed in front of resident. R4 was alert to self but was not interviewable at this time. On [DATE] at 3:12 PM, V15 (Restorative Nurse) said residents with a fall assessment score of 10 or higher indicates they are at a higher risk for falls. V15 added that yellow stars are placed on the doorframes for fall risks, floor mats are initiated for resident with prior falls due to resident trying to climb out of bed, and virtual sense technology (VST) is used for residents with frequent falls. V15 (Restorative Nurse) said her expectation of staff for residents who are at risk for falls is to do frequent rounding at least every 30 minutes, have resident in high visible areas, and to engage them in activities. V15 (Restorative Nurse) said if a fall risk resident is in bed, their bed should be in the lowest position with mats in place to prevent injury, and their call light should be within reach so the resident can utilize it if they need assistance. V15 added that floor nurses should be monitoring to ensure fall interventions are in place on every shift. V15 (Restorative Nurse) and V1 (Administrator) who was present during interview both said that the VST monitors use an infrared light to detect when a resident's a limb goes out of the bed boundary and sends a verbal alarm to the resident to wait for help, an also sends an alert to the nurse's station and the tablets. V1 (Administrator) said between these three alarms, it should alert staff of the resident's movements. V15 said she does daily rounds/audits. Bed positioning can determine number of floor mats, and previous falls indicate if resident fell out of a specific side. Fall Prevention Policy last reviewed/revised [DATE] reads in part: each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls .