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	05/29/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45303 Based on interview and record review, the facility failed to follow their policy to document complete assessments of pressure ulcers. This applies to 3 of 3 residents (R1, R2, and R3) reviewed for pressure ulcers in the sample of 8. The findings include: 1. R1's EMR (Electronic Medical Record) showed R1 was admitted to the facility on [DATE], with multiple diagnoses including orthostatic hypotension, muscle wasting and atrophy of multiple sites, pulmonary embolism, dementia, and stage 3 pressure ulcer of sacral region. R1's pressure ulcer care plan dated January 31, 2025, showed The resident has stage 3 pressure ulcer to the right elbow and sacrum or related to immobility. The care plan continued to show multiple interventions dated January 31, 2025, including Assess/record/monitor wound healing weekly. Measure length, width and depth were (sic) possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the physician. On May 28, 2025, at 1:49 PM, V6 (Wound Care Nurse) said R1 was admitted to the facility on [DATE], from the local hospital with a stage 3 pressure ulcer on his sacrum. V6 said she saw R1's pressure ulcer on February 3, 2025. V6 said the wound doctor assessed R1's pressure ulcer on February 6 and February 20, 2025. V6 said the wound doctor did not see R1 on February 27, 2025, because R1 was not in his room. V6 continued to say she did not assess R1's pressure ulcer during that week either. V6 said there is no documentation of R1's pressure ulcer assessments after February 20, 2025. The facility does not have documentation to show R1's sacral pressure ulcer had a complete assessment conducted including measurements of R1's pressure ulcer and description of the pressure ulcer on admission to the facility and weekly. On May 29, 2025, at 11:18 AM, V2 (DON/Director of Nursing) said V6 should be following the facility policy and documenting in the EMR the complete pressure ulcer assessment including appearance and measurements of the pressure ulcers on admission and at least weekly. V2 said R1 did not have a complete admission wound assessment and had missing weekly wound assessments. (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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. R3's EMR showed R3 was admitted to the facility on [DATE], with multiple diagnoses including fracture of right lower leg, muscle wasting and atrophy, chronic diastolic heart failure, and dementia. R3's skin impairment care plan dated May 20, 2025, showed [R3] has a fractured right leg, skin tears to the bilateral forearms, a deep tissue injury to the left heel and remains at risk for further skin integrity issues related to reduced mobility, aging fragile skin, Braden score of 14. The care plan continued to show multiple interventions dated May 20, 2025, including Follow facility protocols for treatment of injury. On May 29, 2025, at 1:36 PM, V6 (Wound Care Nurse) said R3 was admitted to the facility on [DATE], with a left heel DTI (Deep Tissue Injury). V6 said the wound care doctor was not following R3's wound because the wound was small and stable. V6 said she does not document wound assessments in the EMR. On May 29, 2025, at 11:18 AM, V2 said R3 did not have a complete admission wound assessment or weekly wound assessments. V2 said V6 should have completed and documented these assessments. The facility does not have documentation to show R3's left heel DTI had a complete assessment conducted including measurements of R3's left heel DTI and description of the pressure ulcer on admission to the facility and weekly. 3. R2's EMR showed R2 was admitted to the facility on [DATE], with multiple diagnoses including urinary tract infection, muscle wasting and atrophy, and dementia. R2's pressure ulcer care plan dated March 4, 2025, showed [R2] has stage 4 pressure injury to the sacrum and remains at risk for further skin breakdown related to bowel incontinence, poor mobility, aging fragile skin, Braden scale of 13, diagnosis of muscle wasting. The care plan continued to show multiple interventions dated March 4, 2025, including Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration etc. to physician. On May 28, 2025, at 1:40 PM, V6 said on February 20, 2025, R2 developed a sacral pressure ulcer. On May 29, 2025, at 11:18 AM, V2 said R3 did not have a complete wound assessment for the week of May 15, 2025. V2 said V6 should have documented a complete assessment. The EMR showed R2 was not seen by the wound doctor on May 15, 2025, due to R2 being out of the facility on an appointment. The facility does not have documentation to show R2's weekly pressure ulcer assessment was completed to show description of R2's pressure ulcer and measurements of the pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy titled Documentation of Wound Treatments dated December 2024, showed Policy: The purpose of this policy is to provide a consistent, complete, and accurate documentation of wound assessments and treatments, including response to treatment, change in condition, and changes in treatment. Policy Explanation and Compliance Guidelines: 1. The community [NAME] maintain clinical records on each resident receiving wound treatments in accordance with accepted professional standards and practices that are: a. Complete; b. Accurate; c. Readily Accessible; d. Systemically organized . 3. Wound assessments are documented upon admission, weekly, and as needed if the resident or wound condition deteriorates. 4. The following components are documented as part of a complete wound assessment: a. Type of wound (pressure injury, surgical, etc.) and anatomical location; b. Stage of the wound, if pressure injury (stage I, II, III, IV, deep tissue injury, unstageable) or if non-pressure, the degree of skin loss (partial or full thickness); c. Measurements: height, width, depth, undermining, tunneling; d. Description of wound characteristics: i. Color of the wound bed; ii. Type of tissue in the wound bed (i.e. granulation, [NAME], eschar, epithelium); iii. Condition of the peri-wound skin (dry, intact, cracked, warm, inflamed, macerated); iv. Presence, amount, and characteristics of wound drainage/exudate; v. Presence or absence of odor; vi. Presence or absence of pain .