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	ASL510328	A. BUILDING: _____ B. WING _____	06/26/2026

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SMITH CROSSING	10501 EMILIE LN ORLAND PARK, IL 60467

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A 000	Initial Comment Annual Licensure survey. The following violations were cited: 295.3000 a) h) 1) 2) 3) 295.4010 a) d) e) g) 1) A) C) 2) 3)	A 000		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: Type 1 Violation Section 295.3000 Personnel Requirements, Qualifications and Training a) The establishment shall have staff sufficient in number with qualifications, adequate skills, education and experience to meet the 24 hour scheduled and unscheduled needs of residents and who participate in ongoing training to serve the residents' population. (Section 35(a)(3) of the Act) h) The establishment shall have sufficient personnel to provide the following for its current resident population: 1) All mandatory services. 2) Services established in each resident's service plan. 3) Service to meet the needs of each resident, including 24 hour scheduled and unscheduled needs, general supervision, and the ability to intervene in a crisis; These requirements were not met, as evidenced by:	A3000		

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A3000	Continued From page 1	A3000		

Based on interview and record review, the facility failed to provide monitoring and supervision and implement the physician's recommendations to monitor R1 closley. This failure resulted in multiple falls in which R1 sustained a blunt head injury with a hematoma localized to the left parietal scalp, multiple right-sided rib fractures (2-5), a subcutaneous hematoma and a occipital scalp laceration, requiring four surgical staples.

This failure creates a substantial probability of severe harm or death to one resident or residents.
This applies to one of three residents reviewed for fall incident (R1).

Findings include:

R1 moved into the establishment on March 21, 2026, with diagnosis to include orthostatic hypertension, atrial fibrillation, hypothyroidism, spinal stenosis, chronic obstructive pulmonary disease and with history of syncope.

R1's initial mental status assessment (SLUMS) presented by E1 (Assisted Living Manager) on June 18, 2026, identified R1 with dementia, with a score of 19. R1's functional mobility and fall risk assessment (TUG test) conducted upon admission revealed a result of 30 seconds, identified R1 to have significant walking/balance issues and a likely requirement for assistance with basic activities.

On June 18, 2026, at 2:07 PM, E1 described R1 as alert with periods of confusion, and requiring assistance in toileting and dressing. R1 was described to ambulate with a walking device (i.e., a walker for short distances and a wheelchair for longer distances). E1 also identified R1 as being

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A3000	Continued From page 2	A3000		

"high risk for falls and had a previous fall incident, needing frequent rounds." E1 also expressed that R1's orthostatic hypotension could be a causative factor of R1's multiple fall incidents.

1. R1's admission service plan recorded three (3) incidents of falls: April 11, 2026, April 15, 2026, and April 15th, 2026. The incident reports and nurse's notes for these incidents were requested but were not provided.

2. On April 26, 2021, R1's nurses notes detail an "unwitnessed fall" where at approximately 10:25 PM, R1 was found lying on the floor. R1 was described to have an "unsteady gait." E1 stated, "R1 requires frequent rounding. E1 explained 'frequent rounding' means an "hourly check."

On April 29, 2026, R1's post-Emergency Department visit follow up notes from R1's attending physician documented the following:
- R1 was seen in the hospital emergency room on April 27, 2026, due to a fall.
- Assessment and plan includes:
- Frequent falls with blunt head injury with hematoma on the left parietal scalp.
- Multiple right-sided rib fractures (2-5).
- Discussed with nurses to monitor [R1] closely.

On June 18, 2026, at 12:54 PM, E1 explained most of R1's falls were related to the diagnosis of orthostatic hypotension. E1 also agreed that R1 also has a diagnosis of dementia and requires assistance with toileting.
E1 was unable to show any specific intervention(s) implemented to prevent or minimize R1's fall incidents.

3. The establishment incident notification report

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A3000	Continued From page 3 (reportable) dated May 21, 2026, at 1:00 AM, reads as follows: R1 was observed on the floor. R1 explained they were walking to the bathroom, felt dizzy, lost balance and fell backward. A scalp laceration with bleeding was noted at the back of R1's head. R1's nurses notes document an "unwitnessed fall" with the following predisposing physical factors: confused, gait imbalance, impaired memory and weakness. The notes described that on May 21, 2026, at around 1:00 AM, R1was found on the floor, noted with blood flowing downwards from the back of the resident's head and onto the neck. Blood is noted on the resident's nightstand and floor near the left side of the residence bed. R1 was noted to have sustained a hematoma and laceration to the back of the head. R1 was sent to the hospital and was found to have a subcutaneous hematoma and an occipital scalp laceration requiring four surgical staples. On June 18, 2026, at 1:30 PM, E1 explained, "The majority of R1's falls were at night, with increasing confusion, and the orthostatic hypotension and not pressing the call button are likely the causes of R1's falls." Although R1 scored 19 on the SLUMS Examination upon admission, a result suggestive of significant cognitive impairment and possible dementia, the facility did not recognize or address the implications of this finding in R1's assessment or care plan. E1 also confirmed that there was no preventative plan implemented to specifically address R1's fall risk.	A3000		
A4010	Section 295.4010 Service Plan	A4010		

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A4010	Continued From page 4 This Regulation is not met as evidenced by: Type 1 Violation Section 295.4010 Service Plan a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the residents' choices regarding the service plan. d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act). e) The service plan shall be reviewed and revised, if necessary, immediately after a significant change in the residents' physical, cognitive, or functional condition (see Section 295.4000). g) Service plans shall address: 1) The level of service the residents receive, including: A) assistance with activities of daily living. C) accommodation for the residents. 2) The amount, type, and frequency of health-related services needed by the residents. 3) Staff responsible for the provisions of the service plan. h) The service plan shall include all support services provided or arranged for by the establishment.	A4010		

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A4010	Continued From page 5 These requirements were not met, as evidenced by: Based on interview and record review, the facility failed to develop and implement an individualized plan of care to prevent and minimize falls and analyze the possible root cause(s) of R1's multiple fall incidents and implement specific intervention(s) based on the identified risk factor(s). The facility also failed to develop a significant change of condition to reflect R1's functional and cognitive changes and integrate the outside services into the establishment plan of service. These failures resulted in multiple fall in which R1 sustained a blunt head injury, with hematoma on the left parietal scalp, multiple right side rib fracture (2-5), a subcutaneous hematoma and occipital scalp laceration, requiring four surgical staples. This failure creates a substantial probability of severe harm or death to one resident or residents. This applies to two of seven resident reviewed for compliance in service plan (R1 and R2). The findings include: A. R1 moved into the establishment on March 21, 2026, with diagnoses to include orthostatic hypertension, chronic obstructive pulmonary disease and history of syncope. On June 18, 2026, at 2:07 PM, E1 described R1 as alert with periods of confusion, requiring assistance in toileting and dressing, ambulating with a walking device (e.g., able to walk independently with a walker for short distances and a wheelchair for longer distances), and at "high risk for fall." E1 also reported that R1's fall incidents were related to the diagnosis of	A4010		

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A4010	Continued From page 6	A4010		

orthostatic hypotension and "not pressing the call button."
R1's service plan initiated on March 21, 2026, identify R1 as (1) having inappropriate judgment related to safety, (2) requiring assistance from the staff for toilet use, bathing, and dressing, and (3) requiring assistance from staff for stability with the use of the walker.

1. R1's fall service plan documented five falls over a two-month span: April 11, 15, 21 and 26, 2026 and another fall on May 21, 2026. The following were listed under the intervention section:

- April 11, 2026, R1 can benefit from bilateral support on the toilet to ensure safety and stability during transfers. When asked about this support, E1 said, "I am not sure if R1 has that."
- April 15, 2026, R1 was educated to wear proper footwear slippers when ambulating to and from the bathroom to decrease risk of fall.
- April 21, 2026, R1 was encouraged to utilize alternative seating in apartments until chair is removed to promote safety.
- April 26, 2026, R1 requires a visual reminder to call for assistance.
- May 21st, 2026, R1 was educated with a visual reminder to use the wheelchair during functional tasks to increase safety.
- Is at risk for fall due to (specify) _____.

E1 stated, "Yes, the [fall] risk [factors] were not identified, and I agree the service plan is generic." E1 confirmed that R1 has cognitive deficit and requires assistance with activities of daily living.

2.. On April 26, 2021, R1's nurses notes detail an "unwitnessed fall" where at approximately 10:25 PM, R1 was found lying on the floor. R1 was

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described to have an "unsteady gait." E1 stated, "R1 requires frequent rounding. E1 explained 'frequent rounding' means an "hourly check."

On April 29, 2026, R1's post-Emergency Department visit follow up notes from R1's attending physician documented the following:
- R1 was seen in the hospital emergency room on April 27, 2026, due to a fall.
- Assessment and plan includes:
- Frequent falls with blunt head injury with hematoma on the left parietal scalp.
- Multiple right-sided rib fractures (2-5).
- Discussed with nurses to monitor [R1] closely.

Upon R1's readmission to the community, the establishment did not develop a significant change of condition, and this was confirmed by E1. On June 18, 2026, at 3:15 PM, E1 stated, "I didn't know I need to do that."

3. The establishment incident notification report (reportable), dated May 21, 2026, documents a fall incident at 1:00 AM where R1 was observed on the floor. R1 stated, "I was walking to the bathroom, felt dizzy, lost balance and fell backward." A scalp laceration with bleeding was noted at the back of R1's head.

R1's nurses notes identified this incident as an "unwitnessed fall." This documentation include the following predisposing physical factors such as, "confused, with gait imbalance, impaired memory and weakness. The notes described that on May 21, 2026, at around 1:00 AM, R1was found on the floor, noted with blood flowing downwards from the back of the resident's head and onto the neck. Blood was noted on the resident's nightstand and floor near the left side of the resident's bed. R1 was noted to have

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A4010	Continued From page 8 sustained a hematoma and laceration to the back of the head. R1 was sent to the hospital and was found to have sustained a subcutaneous hematoma and occipital scalp laceration requiring four surgical staples. On June 18, 2026, at 1:30 PM, E1 explained, "The majority of R1's falls were at night, with increasing confusion, and the orthostatic hypotension and not pressing the call button are likely the causes of R1's falls." On June 18, 2026, at 3:55 PM, E1 confirmed that there were no revisions conducted to R1's service plan. B. R2 moved into the establishment on November 25, 2024, with diagnosis to include myelodysplastic syndrome. On June 18, 2026, at 1:00 PM, E1 (Assisted Living Manager) described R2 as independent with all of activities of daily living but under hospice care due to the diagnosis of blood disorder. R2's service plan initiated on November 26, 2024, identified that R2 was admitted under hospice care on June 22, 2025. The hospice care and services were not integrated with the establishment plan of service. On June 18, 2026, this finding was discussed with E1 stated, "I didn't know I should do that! I'm learning!"	A4010		