

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015032		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/21/2026	
NAME OF PROVIDER OR SUPPLIER SMITH VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 2320 WEST 113TH PLACE , CHICAGO, Illinois, 60643			
(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) COMPLETION DATE	
S0000	Initial Comments Complaint Investigation 2589676/2637724		S0000			01/29/2026	
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3240a) 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.		S9999			01/29/2026	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 (Section 2-107 of the Act) These requirements are not met as evidenced by: Based on interview and record review, the facility failed to follow their abuse protocol for one resident (R1) out of four residents reviewed for abuse. This failure resulted in an employee cashing several of R1's personal checks without his knowledge/permission. Findings Include: R1's 7/26/2025, 19:12 Admission Details reads: Arrived by other. Admission mode: wheelchair. Living situation prior to admission: Other residential facility / assisted living / group home. Mental Status: Alert & Oriented x3, communicated verbally, speech is clear, is able to understand and be understood when speaking. R1's 9/4/2025 18:26 Health Status Note Text reads: Resident actively transitioning. Family visiting through shift. Hospice RN made aware and was coming to facility. Resident resting in bed. Oncoming shift aware to monitor. R1's 9/4/2025 19:20 Health Status Note Text reads: Resident being unresponsive and pulseless. Daughter /POA present. Dr. made aware. During interview on 1/15/26 at 5:00pm V5 (Assistant Executive Director) stated she received a message on her voicemail from the daughter of R1. V5 stated the message was regarding R1's daughter wanting to know if a certain person, V1 (Certified Nurse Aide) worked at the facility. V5 stated she told the Administrator that R1's daughter had questions about an employee (V1). V5 stated she and the Administrator called R1's daughter and that was when she told them she was closing her dad's bank estate and found several checks written to V1 and they were cashed in V1's name. Facility's abuse report reads on 10/1/25 the daughter of R1 left voicemail messages that there was suspicious activity on R1's account. On 10/2/25 called R1's daughter, she said that the name on the checks was one of the Certified Nurse Aides (name V1). We called V1 and took his statement over the phone, then suspended him pending a full investigation. After hours that day R1's daughter sent email along with copies of the cancelled checks that in fact have V1's name on them, Chicago Police Department called. On 1/21/26 at 4:50pm V6 (Executive Director/Administrator) stated she got a message to		S9999				

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S9999	Continued from page 2 call R1's daughter. V6 stated R1's daughter asked if they had an employee called (V1's name), because she had seen several checks from her dad with V1's name on them. V6 stated she told R1's daughter they would investigate it and to email them proof of the checks she believed that V1 had cashed. V6 stated she called V1 to get his account on what happened. V1 denied knowing anything and denied seeing any checks. V6 stated she then told V1 he was suspended pending the investigation. V6 stated within a few hours R1's daughter sent them bank statements with copies of cashed checks from R1's account written to V1. V6 stated as soon as she received the copied bank statements sent to them, they contacted the police. On 1/15/26 at 4:45pm V4 (Director of Nursing) stated R1 used to reside on the Assisted Living Side then he was moved to their skilled side in August. V4 stated V1 had been regularly assigned to take care of R1 on the day shift. V4 stated after R1 had passed away his daughter contacted the facility and asked if they had an employee with the name of V1. V4 stated as soon the daughter alleged that V1 might have cashed her father's check he was immediately suspended and told he could not come back into the building until the investigation was completed. V4 stated once the daughter presented to them proof of the cashed checks, V1 was terminated. V4 stated he called V1 on the phone and told him they had to terminate him. V4 stated V1 apologized to them but did not say why he was apologizing just kept saying he was sorry. During interview on 1/15/26 at 5:30 pm, V2 (Human Resource Director) stated an employee cannot be terminated without her prior approval. V2 stated her job is to ensure that termination is legal. V2 stated R1's daughter presented copies of checks written to V1 from R1's bank account. V2 stated legally they had enough evidence to fire V1 for theft. V2 stated they are very strict and will terminate an employee for stealing, regardless of the value. During phone interview on 1/15/26 at 5:45pm V1 (Certified Nurse Aide) stated he did take care of R1 while he was at the facility. V1 stated he stopped showing up to work because he thought some "bull****" was going on. V1 stated he was never told that he was being terminated for stealing R1's checks or using R1's checks. V1 stated someone with his name cashed those checks, it was not him. R1's Check #7472 reads signed by V1 on 8/12/25 for rent in the amount of \$940.00.	S9999					

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S9999	Continued from page 3 R1's Check #7479 reads signed by V1 on 8/19/25 for rent in the amount of \$940.00. R1's Check #7476 reads signed by V1 on 8/28/25 for rent in the amount of \$760.00. R1's Check #7477 reads signed by V1 on 9/1/25 for rent in the amount of \$760.00. R1's Check #7480 reads signed by V1 on 9/2/25 for rent in the amount of \$640.00. R1's Check #7478 reads signed by V1 on 9/3/25 for rent in the amount of \$840.00. R1's Check #7473 reads signed by V1 on 9/5/25 for rent in the amount of \$940.00. R1's Check #7474 reads signed by V1 on 9/6/25 for rent in the amount of \$760.00. R1's Check #7475 reads signed by V1 on 9/7/25 for rent in the amount of \$840.00. V1's Employee Action Form dated 10/6/25 reads it was confirmed that several checks were written to V1 from R1's checking account and were subsequently mobile deposited into a personal account. Based on these findings, the facility has determined that a violation of policy has occurred. V1's Disciplinary Action Documentation dated 10/6/25 reads We are proceeding with immediate termination of employment. Facility's abuse policy reads this facility to provide 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. Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. (B)			S9999			