STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012773	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE CROWNS PARK	2323 MCDANIEL AVE , EVANSTON, Illinois, 60201

(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 Investigation of Facility Reported Incident of 10/25/2025/2659987	S0000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.3210t) 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 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to ensure that 1 of 3 (R1) residents reviewed for abuse in the sample of 3 remained free from physical abuse. This failure resulted in a staff member	S9999		

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

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S9999	Continued from page 1 striking R1's arm and hand and staff member screaming at the resident, causing R1 to cry out in physical pain and emotional distress verbalizing that she was being hurt and abused. Findings include: R1 is cognitively intact 80 year old with diagnoses including but not limited to Parkinson's Disease, Spinal Stenosis and Scoliosis and requires staff assistance for all activities of daily living. On 10/24/25 at 8:30 PM, R1 screamed to the hallway staff stating "Help! Help! Someone help me she is hurting me!" V3, Registered Nurse (RN) responded to the screams and observed V4, Certified Nursing Assistant (CNA) at the bedside providing care. R1 reported that V4 hit her arm and hand multiple times while performing care causing immediate pain. During resident interview on 12/5/25 at 11:45 AM, R1 stated, "Yes I remember what happened, she (V4 CNA) hit me in the arm and my hand hard. I told her she was hurting me and she didn't stop. She was placing me on the sit-to-stand machine and putting this circular thing to go around my waist and when she was hoisting me up, it was hurting me because is was squeezing me in the wrong area and I told her to stop and she just kept going so I screamed stop, stop, stop! So instead of stopping she slapped my arm and hand several times and told me to stop screaming. She was angry with me and that frightened me. That's when the nurse finally came in and told her to move away from me and she (V4) left the room and somebody else came in and helped me. I've had some minor issues with the same CNA, but I just overlooked it before but this time she really hurt me so I had enough." Surveyor asked what minor issues she had with V4, R1 indicated it was the way V4 rushed through things to finish caring for her and that at times she was rough but that she just ignored it until she could no longer. On 12/5/25 at 11:59 am, V2 (Director of Nursing), indicated that the nurse V3 RN called her and gave the reason that she wanted to "rearrange the CNA's" because one of the CNA's (V4) was "giving her a hard time". I told V3 RN that V4 (CNA) needs to be sent home immediately because she just wanted to rearrange the schedule instead of sending the CNA home. I did say to her if the resident said abuse and she said yes so I told V3 that what we are dealing with is allegation of abuse. I texted the executive director (V7) but she did not text me back. I called back and talked to V3 again to ensure that V4 (CNA) left the building. Surveyor asked about R1, V2 indicated that the resident is	S9999		

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S9999	Continued from page 2 cognitive and is not confused and did not have any history of similar allegations. Interview with V3 RN on 12/5/25 at 12:51 PM indicated she heard R1 screaming and heard, "Help! Help! She is hurting me!" so she went to R1's room immediately and observed V4 trying to put R1's socks on the resident. V3 asked R1 what happened and R1 had explained that she did not want V4 to be her aide anymore and that V4 hit her multiple times on the hands and arm and told her to quiet down which frightened her. V3 said that she asked V4 to leave until she called the director of nursing to inform her of the issue. V3 indicated she had called the V7 executive director first but there was no answer or call back. Surveyor asked if she had called the director of nursing for reassignments of her CNA's, V3 affirmed that she did, but that the director of nursing instructed her to go back to the resident to ask if she was abused or not. Surveyor asked when the last time she was trained on abuse prevention, V3 said she could not recall but that she received one after the incident happened. V4 CNA could not be contacted for interview and was terminated from employment for not meeting service standards. V7 executive director was requested for interview but failed to honor surveyor requests during the investigation. V8 interim administrator who created the internal investigation is no longer with the facility. Facility policy on abuse reads in part, "The facility prohibits any form of resident abuse, neglect, or exploitation. Facility shall supervise staff in such manner as to attempt to identify inappropriate behaviors such as rough handling of residents, identifying escalating aggressive behaviors from residents, or imposed seclusion. Staff members shall use the care plan or resident assessment to monitor and identify resident needs and behaviors that have the potential for abuse. All employees are obligated to report knowledge of potential for abuse, neglect, or exploitation of a resident to their immediate supervisor. Physical abuse is the infliction of physical of pain or injury to the resident which includes, but is not limited to, hitting, slapping, pinching, and kicking. "B"	S9999		