STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007462	A. BUILDING: _____ B. WING _____	C 10/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE CROWNS PARK	2320 PIONEER PLACE EVANSTON, IL 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) COMPLETE DATE
S 000	Initial Comments Facility Reported Incident of 9-12-21/IL138303	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. These requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to ensure residents were evaluated and fall interventions were in place to	S9999		

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S9999	Continued From page 2	S9999		

prevent further falls to residents with repeated falls with injuries to two (R1 and R3) of three residents reviewed for falls in the sample of three.

Findings include:

1. R1's electronic medical record accessed on 10/22/21 shows R1 is a 100 year old female resident with diagnoses that include hypertension, repeated falls and dementia.

The Facility Reported Incident final report dated 9/17/21 shows, fall incident - 9/12/21, [R1] returned from ER at 11 PM, with diagnosis of closed fracture of multiple ribs of left side with discharge instructions to monitor resident for fever, chills, nausea vomiting abdominal pain chest pain, trouble breathing inability to tolerate oral intake...therapy ordered for poorly fitting shoes.

On 10/22/21 at 10:00 AM, R1 was lying in bed. An alarm was attached to her bed. R1's walker was by her bed. R1 said she knew she had fallen, "I guess I just lost my balance and fell. I have fallen more than once."

On 10/22/21 at 11:02 AM, V3 (Registered Nurse/RN) said she was R1's regular nurse. V3 (RN) said on 9/12/21 R1 fell by the kitchen doorway on 3rd floor where R1 was a resident. V3 said R1 tripped on her shoes. R1 was wearing flat shoes that were well fitting to R1. V3 said R1's knees buckle at times but R1 likes to walk using her walker. V3 said R1 should be supervised during ambulation to ensure R1 is safe. V3 said R1 continued to have falls. V3 said, "R1 has a bed alarm that we call a 'silent alarm.'" V3 said it does not alarm in R1's room, but it alarms the staff to check on R1. V3 said R1 had

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S9999	Continued From page 3 the alarm prior to the fall incident on 9/12/21. V3 said she was not aware of any new fall precautions or interventions. V3 stated, "We monitor R1 but R1 still falls." R1's progress notes show R1 had further falls after 9/12/21. R1 fell again on 10/10/21 (twice) and 10/16/21. Progress notes on 10/10/21 at 5:29 AM document, "R1 was observed lying on her stomach and face, very close to her bed, R1 unable to tell what happened...2 person assist, was able to walk but very unsteady, took her back to bed." R1 had another fall on 10/10/21 at 10:46 AM. Progress notes document, "R1 was noted on the dining room floor with her back towards the wall. R1 said I was trying to get out of the chair and I fell." R1 fell again on 10/16/21 at 6:37 AM. Progress notes document, "R1 was sitting on the hallway floor close to her room entrance door trying to get up, walker nearby." R1's fall risk assessment dated 10/16/21 shows R1 is high risk for falls. R1's latest care plan did not show any update for new fall interventions or necessary precautions to R1's falls on 9/12/21, 10/10/21 and 10/16/21 to prevent further falls. On 10/22/21 at 12:30 PM, both V1 (Administrator) and V2 (Director of Nursing/DON) said unfortunately R1's care plan did not show any new evaluation and new fall interventions after R1's repeated falls. V2 (DON) said R1's bed	S9999		

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S9999	Continued From page 4 alarm has been in place way before R1 had the fall injury on 9/12/21. V2 said it's time to reevaluate the affectivity of the alarm. V2 confirmed no new interventions were added to R1's plan of care to prevent R1 from falling repeatedly. 2. R3's electronic medical record accessed on 10/22/21 show R3 has diagnoses of Parkinson's disease and Alzheimer's dementia. The Facility Reported Incident Final Report sent to state agency on 9/10/21 shows, incident - 9/5/21 - R3 fell while attempting to self transfer to wheelchair and sustained a right hip fracture. R3 was able to stand and at times capable of self transfer. R3 was sent to emergency room via 911. On 10/22/21 at 10:45 AM, R3 was sitting in her wheelchair in her room watching TV. R3 said she had fallen but she was fine. On 10/22/21 at 12:30 PM, V2 (DON) said R3 was readmitted to the facility on 10/10/21. V2 said on 9/5/21 when R3 was sent to the ER, R3 was diagnosed with right hip fracture and had a surgical intervention. R3 was sent to a rehab facility for therapy. V2 said R3 came back to the facility on 10/10/21. R1's progress notes dated 10/22/21 by V7 (Registered Nurse) document, "R1 had another fall this morning at 1:28 AM. R3 was observed sitting on the floor by her bed. 30 minutes prior to fall, R3 was in bed and call light was within reach." On 10/22/21 at 1:30 PM V4 (License Practical Nurse) said he was R3's nurse today. V4 said he was from agency and was not familiar with the	S9999		

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S9999	Continued From page 5 residents. V4 said he monitors all the residents. On 10/22/21 at 1:10 PM, V5 (Certified Nursing Assistant/CNA) said he works as a regular CNA on 3rd floor where R3 was a resident. V5 stated R3 attempts to transfer herself and does not wait for help. V5 said when they are busy and cannot get to R3 immediately, there was no device to alert staff if R3 was trying to transfer unassisted from bed. V5 said he tries to explain to R3 to be patient. V5 stated, "We try to get to her as soon as we can; that's about it." R3's care plan did not include any fall care plan or fall interventions for R3 since admission day of 10/10/21 (12 days ago). On 10/10/21 at 1:55 PM, V2 (DON) said she was working on R3's fall care plan as of today. V2 said when a resident falls, fall interventions should be put in place specific to the resident to ensure resident's safety. Check the root cause analysis for how to prevent further falls. The facility policy entitled Fall Prevention and Management Protocol dated 10/1/2018 shows, Each resident will be assessed for the risk factors for falling at move in, return from healthcare facility and after a fall in the household. 5. After each fall a licensed nurse will complete an incident form, a fall assessment and update the care plan/service plan. (B)	S9999		