PRINTED: 04/05/2021

FORM APPROVED Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING IL6007462 02/22/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2320 PIONEER PLACE THREE CROWNS PARK **EVANSTON, IL 60201** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) S 000 Initial Comments S 000 Complaint Investigation 2190940/JL130918 S9999 Final Observations S9999 Statement of Licensure Violations (Violation 1 of 2) 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.

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Section 300.3210 General

TITLE

(X6) DATE

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_ C B. WING IL6007462 02/22/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2320 PIONEER PLACE THREE CROWNS PARK **EVANSTON, IL 60201** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S9999 Continued From page 1 S9999 o) The facility shall also immediately notify the resident's family, guardian, representative, conservator and any private or public agency financially responsible for the resident's care whenever unusual circumstances such as accidents, sudden illness, disease, unexplained absences, extraordinary resident charges, billings, or related administrative matters arise. These requirements were NOT MET as evidenced by: Based on interview and record review, the facility failed to notify the responsible party of a change in skin condition for one resident (R1) reviewed for notification of change. Findings include: R1 is a 96 year old male, originally admitted on 6-22-2020 with medical diagnoses that include but are not limited to hyperlipidemia, unspecified dementia and depressive disorder. R1 was transferred to a local hospital on 11-29-2020. On 2-21-2021 at 10:20am V7 (Family Member) stated, "The nursing staff did not report to me or V9 (Family Member) that R1 developed a pressure ulcer while at the facility." On 2-21-2021 at 9:50am V3 (Registered Nurse) stated, "I always called and communicated with the family when there were any changes to R1's condition. I do not remember why I did not document that I informed them that R1 developed a sacral wound." On 2-21-2021 at 11:30am V2 (Director of Nursing) stated, "R1 was here in the facility and he acquired a stage 2 wound to the sacral area.

Illinois D	epartment of Public	Health	<u>.</u>			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  IL6007462		(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B. WING		C 02/22/2021		
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	TATE, ZIP CODE		
TUBE CROWNS PARK 2320 PION		IEER PLACE N, IL 60201	: 	15		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OULD BE COMPLETE	
\$9999	V3 told me the famisee any documents V3 never document On 2-22-2021 at 11 Nursing) stated, "We the patient has a characteristic that is documents the confamily with any characteristic provided do Physician and Powers Programme Company Com	ily was contacted, but I do not ation that they were informed. ted the notification."  :40am V2 (Director of re need to call the family when hanged in condition; my the nurse communicates and versation with the patient's nges. There is no excuse for recument, "Nurse Notification of er of Attorney" dated 10-1-09 consibility of licensed nurses to	S9999			
	notify the Power of of any clinical chan  (Violation 2 of 2)  Section 300.610 R a) The facility shal procedures govern	Attorney or resident guardian ge.  (No Violation Issued)  desident Care Policies I have written policies and ing all services provided by the				
	facility. The written be formulated by a Committee consist administrator, the a medical advisory of nursing and other policies shall comp. The written policies the facility and sha by this committee, and dated minutes.  Section 300.696 In	repolicies and procedures shall Resident Care Policy ing of at least the advisory physician or the committee, and representatives or services in the facility. The sly with the Act and this Part. It is shall be followed in operating the reviewed at least annually documented by written, signed of the meeting.				

Illinois Department of Public Health STATE FORM

K0LR11

Illinois Department of Public Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ C B. WING IL6007462 02/22/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2320 PIONEER PLACE THREE CROWNS PARK **EVANSTON, IL 60201** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S9999 Continued From page 3 S9999 guidelines of the Center for Infectious Diseases, Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services (see Section 300.340): 2) Guideline for Hand Hygiene in Health-Care Settings These requirements were NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to follow their infection control protocol by not performing hand hygiene when performing wound care for three (R2, R3) and R6) residents reviewed for wound care. Findings include: 1. R2 is an 89 year old female originally admitted on 9-11-2017 with medical diagnoses that include but are not limited to dementia without any behavioral disturbance, major depressive disorder and atrial fibrillation. On 2-21-2021 at 11:15am V3 (Registered Nurse) and V6 (Certified Nursing Assistant) were in the room with R2. V3 performed wound care to the left ischial area. V3 was observed changing gloves during wound care but did not perform hand hygiene or wash her hands at the beginning of the wound care treatment or after removing the pair of gloves on three different occasions. On 2-21-2021 at 2:45pm V3 stated, "I know I should have done hand hygiene or wash my hands when I was doing the dressing change, but I did not do it." 2. R3 is a 91 year old female originally admitted

K0LR11

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ C B. WING IL6007462 02/22/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2320 PIONEER PLACE THREE CROWNS PARK **EVANSTON, IL 60201** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S9999 Continued From page 4 S9999 on 7-8-2020 with medical diagnoses that include but are not limited to Alzheimer's disease. Hypertension and pressure ulcers. On 2-21-2021 at 12:45am V8 (Licensed Practical Nurse) performed wound care on R3. V8 was observed wearing gloves, cleaning the wound, removed her gloves on three different occasions and applied a new pair of gloves without performing any hand hygiene or washing her hands. On 2-21-2021 at 2:35pm V8 stated, "I was supposed to wash my hands every time I changed my gloves, but I did not do it. It was my fault." 3. R6 is a 98 year old female originally admitted on 11-25-2020 with medical diagnoses that include but are not limited to myelodysplastic syndrome, megaloblastic anemia and disorder of the skin and subcutaneous tissue. On 2-21-2021 at 2:20pm V4 (Registered Nurse/RN) performed wound care treatment on R6. Surveyor observed V4 wearing gloves and changing them during the wound care observation but did not perform any hand washing or hand hygiene. V4 stated, "I do not know what the hand washing policy here is, but I know I am supposed to wash my hands before starting the treatment and after I removed the gloves. I did not wash my hands before starting the treatment or when I changed my gloves. I did not use any hand sanitizer or wash my hands. I was supposed to perform hand hygiene, but I did not do it." On 2-22-2021 at 10:40am V2 (Director of Nursing) stated, "My expectation is the nursing

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:			C 02/22/2021	
	IL6007462						
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
THREE (	CROWNS PARK		NEER PLACE N, 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	
\$9999	staff needs to perfo hands all the time the including when they patient care. It is un infection control pol Facility provided do	rm hand hygiene or wash their ney use any pair of gloves, changed them during direct acceptable not following the icy."  cument, "Standard Infection 2005 reads: Wash hands	S9999				

Illinois Department of Public Health STATE FORM