STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146199	A. Building B. Wing	12/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Three Crowns Park	2323 McDaniel Ave Evanston, IL 60201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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 [AGE] 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 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.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Respond appropriately to all alleged violations. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct a thorough and accurate investigation into an allegation of abuse for 1 (R1) of 3 residents reviewed for abuse in the sample of 3. The nurse on duty (V3) did not provide immediate protection by removing the alleged perpetrator (V4) from resident contact as required. Instead, the nurse attempted to reassign the CNA to a different resident until she was specifically directed by the Director of Nursing (V2 DON) to remove the CNA from the building. Additionally the facility failed to evaluate relevant evidence, and concluded that the allegation was unsubstantiated. These failures created a facility-wide potential for residents to be placed at risk for unrecognized and/or inadequately investigated allegations of abuse. Findings include:R1 is cognitively intact [AGE] 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. On 10/23/25 at 8:30 PM R1 yelled Help me, help me, she is hurting me! prompting V3 RN to respond. V3 found R1 distressed and removed V4 CNA from the situation and reported that V4 hit her several times which caused her pain. R1 explained to V4 that the sit-to-stand machine was improperly placed on her and that during the lifting process she was telling the CNA V4 she was in pain and to stop, yet she kept continuing the process and instead told the her to be quiet. During interviews on 12/5/25 at 11:45 AM , R1 consistently stated that V4 CNA struck her hand several times along with her arm. 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. Witness statements and the resident's distress were not reconciled or analyzed using the regulatory definition of abuse which defines abuse by the willful infliction of physical pain, and does not require injury or malicious intent. 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 text 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 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. 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. The facility's investigation did not evaluate the resident's distress and immediate outcry as evidence; did not compare the CNA's denial against resident credibility assessment; and did not apply the federal definition of physical abuse, and justified the unsubstantiated finding with clear evidence. As a result, the facility reached a conclusion inconsistent with the regulatory criteria of abuse. 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 and procedures for abuse prohibition reads in part but not limited to, Abuse is any act, failure to act, or incitement to act done willfully, knowingly, or recklessly through words or physical action which causes or could cause mental or physical injury or harm. This includes mental abuse, physical abuse, verbal abuse, or any other actions within this