STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145011	A. Building B. Wing	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpine Care of Evanston	500 Asbury Street Evanston, IL 60202

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **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 residents (R1) was treated with dignity and respect during care interactions and administrative care plan meetings reviewed for dignity from the sample of 3. R1 is a [AGE] year-old with diagnoses including but not limited to Meniere's Disease, PTSD, and Acute Metabolic Acidosis.R1's MDS dated [DATE] section C for cognition shows R1 with a BIMS (Brief Interview for Mental Status) of 15 demonstrating cognitively intact. On 01/09/2026, R1 reported that V14 LPN slammed medications onto her table and said a profanity while giving her her medications. The resident subsequently overheard the nurse refer to her as a f***ing problem.During a care plan meeting, the Administrator (V1) allegedly threatened R1 and her husband with eviction and being banned from the facility if they continued to voice grievances, stating the facility is not a hotel.On 1/14/26 at 11:00 AM R1 was seated up in bed on the telephone with (husband) and surveyors asked to speak with the resident. Resident appeared alert, oriented to self, time, and place, and situation and said that last Friday night V14 (LPN) the nurse slammed medications down on her bedside table and said Shut the f*** up. Here's your f***ing medication then preceded to walk out and she overheard the nurse and CNA talking and heard her say, That bitch is a f***ing problem. Started with resident pulling the call light and it took about 10 min for someone to come and then the CNA a tall black man (later identified as V16 CNA) came in didn't talk and just cowered over her and she requested him to assist her to get to her bedside commode. Resident said that the CNA said nothing, didn't instruct her or guide her on what to do, and just stood there and extended his arm. V16 didn't use his gait belt and said that she was afraid she would fall but the CNA didn't do anything and when she sat on the commode she asked him to stay nearby but instead left the room. She asked him to get the nurse because she had pain in her stomach and had gas pain and chest hurt. she asked for tums and for Tylenol. This is when the nurse was very mad, and slammed the pills down (R1 demonstrates how she slammed the pills that were in the cup) and started using profanity. R1 went on to say that they had a care plan meeting in her room with the administrator (V10 , DON, V2, therapy V11 and Restorative nurse V9 and she thinks the wound nurse. R1 said the administrator said that this is not a hotel and threatened her and her husband that she would be thrown out and banned from the place if her husband kept screaming at the staff and if she did the same. Resident denies screaming at the staff but is frustrated that she does not get baths as requested due to her illness and requires baths daily. (a sign on wall from management says she is to receive baths daily). Says that it frustrates her that they claim she refuses therapy but that she refused once because she is claustrophobic and has to go into the elevator to go to basement to receive therapy. R1 said they just discontinued her therapy and said that they were not given any notice from insurance saying she could no longer receive any therapy but only restorative. on 1/14/26 at 1:45 PM V14 LPN, said that she attended to R1's call light and that she was screaming and screaming so she could get some antacid (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication which she gave the resident but that the resident kept screaming and was offered a Tylenol. V14 denied saying anything to the resident and indicated she did not use profanity towards the resident. Surveyor asked if she was upset with the resident, V14 said, I was not upset with her. She (R1) has anxiety and PTSD. On 1/14/26 at 2:30 PM, V16 CNA said that the resident R1 and asked him to come in to the room to assist her to get on the commode which he obliged doing. V16 went on to say he witnessed the nurse V14 being rude to the resident but that the resident was screaming for medications and kept screaming even after being given the medications but believed that the nurse was lacking in professionalism by being rude to the resident. When asked specifically what he heard the nurse saying, V16 could not recall the exact words but just said it was rude and harsh. On 1/14/26 at 2:45 PM, V1 administrator affirmed he was in the care plan meeting with the resident and husband but denied threatening either of them for eviction nor said anything derogatory to the resident pertaining to her appearance. V1 did however comment on the resident's food choices because of his own personal experiences with diabetes. V1 added that there may have been a comment pertaining to the facility not being a hotel because the husband and resident had unrealistic expectations of the facility. As a recap: On 01/09/2026, R1 reported that a nurse displayed a lack of professional customer service by using inappropriate language and slamming medication cups onto the bedside table during a routine medication pass.During a care plan meeting on 01/15/2026, the facility administration failed to maintain a supportive environment by making insensitive remarks regarding the resident's medical diagnosis and physical appearance. Specifically, the Administrator V1 suggested the resident's health condition was a direct result of personal habits, which the resident found demeaning.A staff member failed to provide proper guidance or verbal instruction to R1 during a transfer to a bedside commode and left the resident unattended against her expressed preference for a staff presence.These failures left R1 feeling frustrated and disrespected by staff, undermining the facility's responsibility to provide care in a manner that maintains or enhances each resident's dignity and individuality.