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	02/19/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure appropriate monitoring and supervision to a resident with known fall risk and impaired safety awareness to prevent accident hazards for 1 (R1) of 3 residents reviewed for supervision needs in the sample of 3.Findings include:R1 is a [AGE] year-old male admitted to the facility on [DATE] with diagnosis including but not limited to Difficulty in Walking; Unspecified Cataract; Hyperlipidemia; Personal History of Other Malignant Neoplasm Of Skin; Hypothyroidism; Nontraumatic Subdural Hemorrhage; History of Falling; Cerebral Edema; Essential (Primary) Hypertension; Attention-Deficit Hyperactivity Disorder; and Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms.According to R1's MDS (Minimum Data Set) assessment dated [DATE] under section C, R1 has no BIMS (Brief Interview of Mental Status) score, short-term and long-term memory problems. According to R1's MDS (Minimum Data Set) assessment dated [DATE] under section GG, R1 requires substantial/maximal assistance with toilet transfers. Absent is documented fall plan to show R1's fall prevention interventions. On 2/17/2026 at 12:37 PM Per record review, R1 hospitalized on [DATE] with not return to the facility.On 2/17/2026 at 1:08 PM V4 (Licensed Practical Nurse) said, R1 was admitted to the facility for only brief time, less than 24 hours. R1 was blind, alert x 3, and able to carry a conversation. On 1/31/2026 on day shift (7:00 AM - 3:00 PM), we had clinical students in the facility following our CNAs (Certified Nurse Assistants). R1 was assigned to V5 (Certified Nurse Assistant) that day. I was told that R1 was placed in the bathroom by clinical student. R1 was urinating on the floor, so the student left to get help to clean the mess, and by the time they came back, R1 was on the floor. It appeared that R1 slipped on the wet floor. R1's head was leaning against the wall. I was called, among other staff, to get R1 off the floor. At the time of my assessment, R1 did not have any visible injuries. I notified the doctor, let the doctor know that R1's fall was unwitnessed and R1 was on anticoagulants, so R1 was sent to the hospital. After R1 went out to the hospital, V6 (Family Member) said R1 will not be coming back to the facility. R1 was diagnosed with subdural hemorrhage. R1 was at high risk for falls. The only fall prevention intervention that I remember was that R1 had a bed alarm. Upon admission to the facility, V6 (Family Member) made us aware that R1 requires constant monitoring due to blindness. R1 was complaisant, wasn't trying to get out of bed or anything.On 2/18/2026 at 11:07 AM V5 (Certified Nurse Assistant) said, I was assigned to R1 on 1/31/2026 7:00 AM - 3:00 PM. I remember that R1 was blind, alert but a little confused. A clinical student and I took R1 to the bathroom early in the day. R1 was peeing on the floor. I tried to redirect him, but R1 insisted he knew what he was doing. R1 was somehow difficult to redirect. We finished cleaning R1 up, getting him dressed, put R1 back in the wheelchair, and left the room. During lunch time, we were passing food trays. R1 needed feeding assistance. I asked the clinical student to assist R1 with feeding. From my understanding, R1 requested to go to the bathroom during lunch meal. The clinical student came out to grab me to let me know that R1 was attempting to (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	get up, and when I came into the room, R1 was already on the bathroom floor. There was a puddle of urine on the floor. I called for help, we got R1 off the floor with a gait belt and sheet and put him back into bed. R1 seemed fine, he kept saying he was fine. In the morning report, I was told that R1 is blind and needs assistance with feeding, I also figured he is a fall risk. R1 had bed alarm. R1 was transferred from bed to chair and bathroom with a gait belt. R1 wasn't great at following directions, very stubborn. On 2/18/2026 at 11:44 AM V2 (Director of Nursing) said, R1 was admitted to the facility on [DATE] and stayed here less than 24 hours. After getting a referral packet, we knew R1 was a high risk for fall. When there is a high-risk resident coming into the facility, we apply bed and chair alarm, we also try to place residents near the nursing station. R1 was placed in the furthest room from the nursing station because we didn't have available room near the nursing station, but we were anticipating room close to the nursing station to become available, so this was not a permanent room placement. R1's fall was investigated by V8 (Fall Coordinator). Clinical students cannot provide accurate monitoring and supervision for residents. Proximate supervision means that facility staff should be physically present with clinical students while providing direct patient care. We didn't report R1's fall. We report fractures or active hemorrhage. Based on R1's record, he had ongoing issues related to brain procedures and prior subdural hemorrhage as well. Based on the hospital record, we determined that we were not sure if this was an acute hemorrhage and after consulting with our former administrator, who's no longer here, we decided not to report this incident. Per record review, progress note dated 1/31/2026 written by V4 (Licensed Practical Nurse) reads in part, Vital Signs: BP 120/87 P 97 R 18 O2 97.0% RA T 98.3. Around 12:10 pm, CNA notified NOD that (R1) is on the ground. NOD went to assess resident and observed him sitting on the bathroom floor with his head against the door. Vitals were obtained. (R1) denies pain or discomfort. No visible injuries noted. Resident stated, I was coming out of the bathroom, but I slipped and fell. Resident was assisted back to his wheelchair by 3 CNA. MD paged and gave an order to send a resident to (local) Hospital ER for further eval. (V2) DON notified. (V6) made aware. 911 called. Around 12:35pm, (R1) transferred to (local) Hospital ER. Per record review, R1's Fall Risk Evaluation performed on 1/30/2026 scores him at 6, indicating low risk for fall.Per record review, R1's hospital record dated 1/31/2026 shows Stable appearance of a 7 mm subdural hemorrhage along the parieto-occipital convexity. In the setting of recent trauma, CT cannot definitely distinguish between a density that reflects a superimposed hyperacute/acute hemorrhage (subarachnoid or subdural), which cannot be entirely excluded.The facility Student Facility Responsibility policy (no date) reads in part, Patient Care. While at the Facility, students and faculty are not to replace the Facility staff and are not rendering service except as identified for educational value and delineated in the jointly planned educational experiences. Any such direct contact between a student and a patient shall be under the proximate supervision of a member of the staff of the Facility.