STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpine Care of St. Charles LLC	611 Allen Lane Saint Charles, IL 60174

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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to notify the physician of a resident's (R8) unwitnessed fall incident, who was then experiencing acute right hip pain.This failure resulted in R8 receiving delayed medical care for her right hip fracture.This applies to 1 of 7 residents (R8) reviewed for fall incidents in the sample 10. The Findings include:On 3/19/2026 at 3:00 PM, R8 was in bed, lying on a mechanical lift sling. R8 was unable to provide information regarding her fall incident on 3/01/2026 due to her cognitive impairment and communication barrier.R8's MDS (Minimum Data Set) dated 1/30/2026 said she was severely cognitively impaired.On 3/20/2026 at 9:50 AM, V11 (Certified Nurse Assistant/CNA) said she routinely took care of R8, and prior to 3/02/2026, she required minimal to partial assistance with her transfers. V11 said on 3/02/2026 at approximately 5:45 AM, when she assisted her with dressing in bed, R8 vocalized acute pain in her right leg. V11 said she became concerned and stopped rendering care and consulted V9 (Agency Registered Nurse/RN). V9 informed her that she had just administered an analgesic to R8. V11 said she then inquired if R8 had a recent incident, such as a fall, because her leg pain was new. V9 informed her that there was no incident reported or recorded in R8's EMR (Electronic Medical Record). V11 said she then proceeded to transfer R8 with a gait belt, and R8 now required extensive assistance. V11 said R8 guarded her right lower leg and was unable to bear weight. V11 said she was further concerned and updated the V10 (RN), the oncoming morning nurse, and again was instructed to continue to provide routine care to R8. V11 said she then transported R8 to the dialysis unit, and again when she transferred her to the dialysis recliner chair, she vocalized discomfort in her right leg. V11 said she then informed V15 (Dialysis RN) of R8's acute pain. V11 continued to say that at 11 AM, she again transferred R8 to her wheelchair after her dialysis treatment and transported to the therapy gym. V11 said she then informed V16 (Occupational Therapist/OT) because she was extremely concerned about R8. V11 said at 1 PM, when she transferred R8 to bed, she now required maximum to total assistance with her transfer and was still experiencing acute pain.On 3/20/2026 at 11:10 AM, V9 (Agency RN) said she was assigned to R8 on 3/01/2026 from 10 PM-6 AM. V9 said she was not notified of R8 having an incident when she received hand-off report from V8 (RN).R8's EMAR (Electronic Medication Administration Record) for March 2026 showed V9 administered Acetaminophen 650 MG (milligrams) by mouth at 4:40 AM for pain.On 3/20/2026 at 11:20 AM, V13 (Agency CNA) said he was assigned to R8 on 3/01/2026 from 10 PM-6 AM. V13 said he was instructed that R8 required minimal assistance with her transfers. V13 said R8 requested to be toileted, and she had to pivot to transfer into her wheelchair. V13 said he was not notified of R8 having an incident on the prior shift.On 3/20/2026 at 11:30 AM, V15 (Dialysis RN) said on 3/02/2026 R8 verbalized ouch when V11 transferred her into the dialysis chair. V11 then informed her that R8 was vocalizing acute pain in her right lower leg. V15 said she notified V10 (RN) and was not made aware of her having any recent incident.R8's Dialysis Communication Report sheet dated 3/02/2026 requested updated information from the nursing team, including whether R8 had any change in condition, such as a recent fall.On 3/20/2026 at 2 PM, V16 (OT) said on 3/02/2026, R8 was unable to safely stand during therapy and started to yell in pain when she removed the wheelchair's right footrest. V16 said she was not notified of R8 having any recent (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 0580 Level of Harm - Actual harm Residents Affected - Few	incidents. V16 said if a resident was experiencing acute pain and had recently sustained a fall, she would not have provided therapy services till they were fully evaluated for a possible acute injury.R8's OT Treatment Encounter Note dated 3/02/2026 said pt [patient] verbalized pain but unable to grade. Pt was screaming and holding RLE when RLE was moved.On 3/20/2026 at 12 PM, V10 (RN) said she was assigned to R8 on 3/02/2026 from 6 AM-10 PM. V10 said she was not notified of R8 having an incident when she received the report. V10 said she reported R8's right hip pain to V4 (Physician) during passing and received an order for a routine x-ray, which was done after 7 PM. V10 said that if she had been aware of R8's fall incident on 3/01/2026, she would have notified V4 to ensure an acute focus assessment was done and recommended a STAT (immediate) x-ray.R8's Radiology Report dated 3/02/2026 said her right hip x-ray was reviewed remotely at 11:30 PM and was found to have a subcapital fracture to the right femoral neck.On 3/20/2026 at 11 AM, V12 (CNA) said on 3/01/2026 at approximately 6:30 PM during rounds, she observed R8 on the floor next to her bed in a sitting position. V12 said she notified V8 (RN), and after she assessed R8, they transferred her back to bed. V12 said they carried R8 off the floor by lifting her under her arms.On 3/20/2026 at 11:50 AM, V8 (RN) said she was assigned to R8 on 3/01/2026 from 2 PM-10 PM, and R8 had an unwitnessed fall from her bed. V8 said she assisted V12 (CNA) in transferring R8 back to bed. V8 said she did not think R8 had sustained an injury. V8 said she did not document the incident in R8's EMR and did not notify V4 (Physician). V8 said in retrospect she should have notified V4 of the incident to ensure the physician could have assessed the situation and determined R8's medical care needs.On 3/20/2026 at 12:45 PM, V4 (Physician) said she was not notified of R8's fall incident on 3/01/2026. V4 said on 3/02/2026, she was still not notified of her fall incident despite her experiencing acute right hip pain. V4 said if she had been notified appropriately of R8's unwitnessed fall incident, she would have further assessed her, ordered STAT testing, or transferred her to the hospital sooner to ensure she did not have a delay in medical care. V4 said when she was notified of R8's right hip fracture, she ordered her to be transferred to the hospital for an emergency evaluation and treatment. V4 said R8 required orthopedic surgery for her right femur fracture.R8's progress note dated 3/03/2026 said X-ray result received @ 1 am, per X-ray for further evaluation. MD and DON made aware. To send to [Hospital]. [Ambulance] called @ 1:16 am. Pain complained on R hip/thigh area.Pt left with [Paramedics] @ 3:12 AM.On 3/20/2026 at 12:10 PM, V14 (RN/Fall Coordinator) said nurses were expected to notify the physician of all fall incidents as per policy. V14 said V8 (RN) received counseling after R8's acute fracture was discovered, and then afterwards identified R8 had sustained an unwitnessed fall on 3/01/2026 that was not reported.The facility's policy titled Notification of Change of Condition, dated 7/02/2025, said the facility would provide care to residents and notification of change in status. The facility would immediately inform the resident's physician of a. An accident involving the resident which resulted in injury and has the potential for requiring physician interventions, b. A significant change in a resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); c. A need to alter treatment significantly.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to document, report, and monitor a resident (R8) after she sustained an unwitnessed fall and was then experiencing acute right hip pain.This failure resulted in R8 not being properly assessed for post-fall complications and receiving delayed medical care for her right hip fracture.This applies to 1 of 7 residents (R8) reviewed for falls in the sample of 10. The findings include:On 3/19/2026 at 3:00 PM, R8 was in bed, lying on a mechanical lift sling. R8 was unable to provide information regarding her fall incident on 3/01/2026 due to her cognitive impairment and communication barrier.R8's MDS (Minimum Data Set) dated 1/30/2026 said she was severely cognitively impaired.On 3/20/2026 at 11:00 AM, V12 (Certified Nurse Assistant/CNA) said on 3/01/2026 at approximately 6:30 PM during rounds, she observed R8 on the floor next to her bed in a sitting position. V12 said she notified V8 (Registered Nurse/RN), and after she assessed R8, they transferred her back to bed. V12 said they carried R8 off the floor by lifting her under her arms.On 3/20/2026 at 11:50 AM, V8 (RN) said she was assigned to R8 on 3/01/2026 from 2 PM-10 PM, and R8 had an unwitnessed fall from her bed. V8 said she assisted V12 (CNA) in transferring R8 back to bed. V8 said she did not think R8 had sustained an injury. V8 said she did not document the incident in R8's EMR (Electronic Medical Record) and did not notify V4 (Physician) and the nursing team. V8 said in retrospect she should have documented and made notifications to ensure that R8 was monitored for post-fall complications and received appropriate care.R8's fall incident report dated 3/01/2026 said she had an unwitnessed fall in her room at 5:30 PM and was observed sitting next to her bed. The report said R8 was unable to provide details regarding the incident and was transferred back to bed. The report indicated that the incident document was Privileged & Confidential- Not Part of the Clinical Record- Quality Assurance Only.On 3/20/2026 at 11:10 AM, V9 (Agency RN) said she was assigned to R8 on 3/01/2026 from 10 PM-6 AM. V9 said she was not notified of R8 having an incident when she received a report from V8 (RN). V9 continued to say R8's EMR did not indicate she had a fall on the prior shift. V9 said she did not perform post-fall assessments for R8.On 3/20/2026 at 11:20 AM, V13 (Agency CNA) said he was assigned to R8 on 3/01/2026 from 10 PM-6 AM. V13 said he was instructed that R8 required minimal assistance with her transfers. V13 said R8 requested to be toileted, and she had to pivot to transfer into her wheelchair. V13 said V12 (CNA) and V8 (RN) did not notify him of R8's fall incident on the prior shift.On 3/20/2026 at 9:50 AM, V11 (CNA) said she routinely took care of R8, and prior to 3/02/2026, she required minimal to partial assistance with her transfers. V11 said on 3/02/2026 at approximately 5:45 AM, when she assisted her with dressing in bed, R8 vocalized acute pain in her right leg. V11 said she became concerned and stopped rendering care and consulted V9 (Agency RN). V9 informed her that she had just administered an analgesic to R8. V11 said she then inquired if R8 had a recent incident, such as a fall, because her leg pain was new. V9 informed her that there was no incident reported or recorded in R8's EMR. V11 said she then proceeded to transfer R8 with a gait belt, and R8 now required extensive assistance. V11 said R8 guarded her right lower leg and was unable to bear weight. V11 said she was further concerned and updated the V10 (RN), the oncoming morning nurse, and again was instructed to continue to provide routine care to R8. V11 said she then transported R8 to the dialysis unit, and again when she transferred her to the dialysis recliner chair, she vocalized discomfort in her right leg. V11 said she then informed V15 (Dialysis RN) of R8's acute pain. V11 continued to say that at 11:00 AM, she again transferred R8 to her wheelchair after her dialysis treatment and transported to the therapy gym. V11 said she then informed V16 (Occupational Therapist/OT) because she was extremely concerned about R8. V11 said at 1 PM, when she transferred R8 to bed, she now required maximum to total assistance with her transfer and was still experiencing acute pain.On 3/20/2026 at 11:30 AM, V15 (Dialysis RN) said on 3/02/2026 R8 verbalized ouch when V11 transferred her into the dialysis chair. V11 then informed her that R8 was vocalizing acute pain in her right lower leg. V15 said she notified V10 (RN) and was not made aware (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	of her having any recent incident.R8's Dialysis Communication Report sheet dated 3/02/2026 requested updated information from the nursing team, including whether R8 had any change in condition, such as a recent fall.On 3/20/2026 at 2 PM, V16 (OT) said on 3/02/2026, R8 was unable to safely stand during therapy and started to yell in pain when she removed the wheelchair's right footrest. V16 said she was not notified of R8 having any recent incidents. V16 said if a resident was experiencing acute pain and had recently sustained a fall, she would not have provided therapy services till they were fully evaluated for a possible acute injury.R8's OT Treatment Encounter Note dated 3/02/2026 said pt [patient] verbalized pain but unable to grade. Pt was screaming and holding RLE when RLE was moved.On 3/20/2026 at 12:00 PM, V10 (RN) said she was assigned to R8 on 3/02/2026 from 6 AM-10 PM. V10 said she was not notified of R8 having a fall incident when she received the report. V10 said she did not perform post-fall assessments for R8. V10 continued to say she then reported R8's right hip pain to V4 (Physician) during passing and received an order for a routine x-ray, which was done after 7 PM. V10 said that if she had been aware of R8's fall incident on 3/01/2026, she would have further assessed R8 for post-fall complications and notified V4 to ensure an acute focus assessments were done and recommended a STAT (immediate) x-ray.R8's Radiology Report dated 3/02/2026 said her right hip x-ray was reviewed remotely at 11:30 PM and was found to have a subcapital fracture to the right femoral neck.On 3/20/2026 at 12:45 PM, V4 (Physician) said she was not notified of R8's fall incident on 3/01/2026. V4 said on 3/02/2026 that she was still not notified of her fall incident despite her experiencing acute right hip pain. V4 said if she had been notified appropriately of R8's unwitnessed fall incident, she would have further assessed her, ordered STAT testing, or transferred to the hospital sooner to ensure she did not have delay in medical care. V4 said when she was notified of R8's right hip fracture, she ordered her to be transferred to the hospital for an emergency evaluation and treatment. V4 said R8 required orthopedic surgery for her right femur fracture. V4 continued to say that she expected the facility to follow its post-fall protocol to ensure residents were being assessed and monitored for complications appropriately.R8's progress note dated 3/03/2026 said X-ray result received @ 1 am, per X-ray for further evaluation. MD and DON made aware. To send to [Hospital]. [Ambulance] called @ 1:16 am. Pain complained on R hip/thigh area.Pt left with [Paramedics] @ 3:12 AM.On 3/20/2026 at 12:10 PM, V14 (RN/Fall Coordinator) said all fall incidents had to be reported to ensure nursing staff were aware and continued to monitor for post-complications to prevent delay in care for possible acute injuries. V14 said nurses were expected to assess residents after they had fallen for 72 hours, and if unwitnessed, they had to initiate neurological assessments. V14 said all post-fall documentation assessments had to be recorded in the residents' EMR. V14 continued to say that fall incident reports were supposed to be integrated into the residents' EMR to ensure staff and providers were aware of the incident. V14 reviewed R8's EMR and said there was no documentation and post-fall assessments for R8's unwitnessed fall on 3/01/2026.The facility's policy titled Fall Occurrences, dated 6/30/2025, said an incident report would be completed by the nurse each time a resident falls. The incident may be written in the nurses' notes or other parts of the resident's medical record that will remain accessible to any person who has the right to access the resident's record. The policy did indicate the facility's procedure for post-fall monitoring and documenting.