STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145433	A. Building B. Wing	04/21/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pressure ulcer prevention interventions for a resident with known risk for pressure ulcer development. This failure applies to 1 of 4 (R5) residents reviewed for pressure ulcers.The findings include:R5's EMR (Electronic Medical Record) said she was admitted to the facility on [DATE] following left hip surgery. R5's MDS (Minimum Data Set) dated 4/13/2026 said she was admitted with two pressure ulcers, an unstageable and a deep tissue injury (DTI). R5's EMR said she had an unstageable ulcer to her left heel and DTI to her left buttock.R5's skin care plan said she was at a high risk for pressure development based on her Braden assessment score of 12, known skin breakdown, and incontinence of bowel and bladder.On 4/14/2026 at 11:20 PM, R5 was in bed, lying on her back. R5 appeared confused and called out for assistance but appeared to be unsure of what she needed. R5 then requested to be toileted. At 11:40 AM, V14 and V15 (Certified Nurse Assistants/CNAs) said R5 required 2-person assistance with turning because of her left lower leg. They turned her on her right side to remove her incontinence brief. R5's brief was heavily soiled with urine and smeared feces. R5 had a DTI to her left buttock and a separate open area to her sacrum. V14 said he had last provided incontinence care to R5 at the beginning of the shift around 6 AM-7 AM (more than four hours prior) and R5 did not have an open area to her sacrum. V14 said he would inform V17 (Wound Care Nurse/WCN).On 4/14/2026 at 12:20 PM, V17 (WNC) said R5 had two pressure ulcers to her left heel and left buttock, both present on admission. V17 proceeded to assess R5's buttock and said she now had a new open wound to her sacrum, which was not present when she assessed her skin early in the morning around 6 AM. V17 said R5's sacral open wound was a stage 2 pressure ulcer that measured 5 x 1.8 x 0.1 cm (centimeters) with purple discoloration to the per-wound area.V17's skin note dated 4/14/2026 said a skin assessment was performed on R5 and was identified with a new skin alteration. The note said, sacrum was noted with superficial skin opening, measuring 5 x 1.8 x 0.1 peri-wound shows intact with discoloration. V17's note said that prior to her sacral assessment, she had also assessed R5's skin and performed wound care to her left buttock DTI and left heel unstageable ulcers.On 4/15/2026 at 9:20 AM, V17 (WCN) said R5's new sacral ulcer and admitted with left buttock DTI were being treated with (moisture barrier cream) and kept open to air. V17's said R5 had multiple skin prevention interventions, including for CNAs to apply the barrier cream when providing incontinence care. V17 said incontinence care should be provided at least twice a shift, at the beginning and end of the shift. V17 then continued to say that for residents who were cognitively impaired, like R5, they should be checked and changed at a minimum every 3 hours.On 4/15/2026 at 1 PM, V2 (Director of Nursing/DON) said nursing staff were expected to assist residents with their toileting needs as indicated in their plan of care. V2 said incontinent residents should be checked and changed at least every 2-3 hours to prevent skin breakdown, skin infections, and to relieve pressure.The facility's policy titled Incontinence Care dated 04/2026, said staff was provide care to residents who had incontinence episodes, and incontinence care should be repeated after each episode of urinary and/or fecal incontinence.The facility's policy titled Pressure Ulcer Prevention and Treatment Interventions, dated 04/2026, said the purpose of the policy was to provide guidance for (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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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pressure ulcer prevention and treatment interventions. The policy said incontinence and moisture management was required for residents, and they should be assessed and treated for incontinence care based on their needs.

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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 - Some	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 observation, interview, and record review, the facility failed to implement fall and safety interventions for residents identified at a high risk for falls. This applies to 4 of 5 (R3, R4, R5, and R6) residents reviewed for falls.The findings include:1. R3's MDS (Minimum Data Set) dated 1/15/2026 said she was severely cognitively impaired and required substantial to maximal assistance with her transfers and dressing. R3's Fall Risk assessment dated [DATE] said she had a history of falls and was at a high risk for falls.On 4/14/2026 at 1:40 PM, R3 had a fading yellow-purple bruise on her right eye's orbital area and was severely cognitively impaired. V15 (Certified Nurse Assistant/CNA) then transferred R3 to the bathroom with the use of a gait belt. R3's gait was slow and at times unsteady. V15 said R3 required extensive step-by-step cues with her care and transfers to ensure her safety. V15 said R3 was a high risk for falls. V15 continued to say R3 had recently fallen and sustained an injury to her right eye.R3's Skin/Wound Evaluation form dated 4/09/2026 said she sustained a partial laceration to the right eyebrow. The wound measured 0.5 x 1.0 x 0.1 cm (centimeters) and required the application of steri-strips.On 4/17/2026 at 2 PM, V27 (Agency CNA) said he transferred R3 to bed on 4/08/2026. V27 said he then turned away from her and walked across the room to get a gown for her. V27 then noticed R3 falling out bed and he tried to hold her from falling but was unsuccessful. V27 said R3 somehow hit her head on the furniture and sustained an injury to her right eye.R3's witnessed fall incident report dated 4/08/2026, said R3 had fallen at 8:20 PM from her bed when she was being assisted with her transfer and bedtime care by her assigned CNA. The report said R3 was unable to give a description of the event and sustained a laceration to her right eyebrow.On 4/17/2026 at 1 PM, V3 (Restorative/Fall Nurse) said she investigated R3's fall incident and determined V27 was unable to intervene in R3's fall from bed after he transferred her. V3 said V27 should have been prepared with all R3's bedtime linens, clothing, and other prior necessities prior to assisting her with her bedtime routine.R3's fall care plan showed it has not been updated since 6/29/2025. No new interventions were put in place after R3's 4/8/2026 fall.2. R4's MDS dated [DATE] said he was severely cognitively impaired. Also, he required partial to moderate assistance with his wheelchair mobility and substantial to maximal assistance with transfers. R4's Fall Risk assessment dated [DATE] said he had a history of falls and was at a high risk for falls.On 4/14/2026 at 1:15 PM, R4 was in his wheelchair. R4 had multiple skin tears on both his arms and was severely cognitively impaired. R4 was unable to say how he sustained his injuries. V15 (CNA) and V17 (Wound Care Nurse/WNC) said R4 was a high risk for falls and had sustained his skin tears after he fell on 4/03/2026. V15 said R5 had to be supervised when he was up in his wheelchair at the nurses' station to ensure he was being safely monitored. R4 was seated on a black cushion, which was neither a wedge cushion or a pommel cushion. V17 verified there was no (anti-slip material) present in R4's wheelchair either.On 4/15/2026 at 10:25 PM, V20 (Registered Nurse/RN) said R4 was a high risk for falls, and his fall prevention interventions included he be monitored at the nurses' station when up in his wheelchair. V20 said on 4/03/2026 at 2:15 PM, R4 was at the nurses' station when he propelled himself down the hallway away from the nurses' view and then slid off his wheelchair. V20 said he sustained skin tears to the left elbow and the back of his right hand.R4's unwitnessed fall incident report dated 4/03/2026 said R4 was observed on the floor in a lying position in front of the nurses' station. R4's reports showed he said he slid on the floor and hit his head slightly. The report said R4 sustained skin tears on his arms.On 4/17/2026 at 1 PM, V3 (Restorative/Fall Nurse) said she investigated R4's fall incident, and unfortunately, he was unable to describe what had occurred prior to the incident, but said he slid off his wheelchair. V3 continued to say that she determined his fall intervention was the hospital treatment he received for his chronic anemia. V3 said R4 had multiple falls and would now consider therapy fall prevention recommendations to ensure his safety.On (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/17/2026 at 12 PM, V4 (Therapy Director) said R4 was a high fall risk, and therapy had made multiple recommendations to V3 prior to his recent fall on 4/03/2026. V4 said the recommendations included an abductor pillow to be placed between R4's legs and a pommel (wedged) wheelchair cushion. V4 continued to say that even the use of a (anti slip pad) to the wheelchair could prevent him from sliding off his wheelchair.R4's therapy communication sheets dated 3/26/2026 and 4/02/2026 said they recommended he use an abductor wedge due to his poor safety awareness when up in his wheelchair.R4's fall care plan was last updated on 1/25/2026. No new fall interventions were implemented after his fall incident on 4/03/2026.3. R6's MDS dated [DATE] said she was cognitively impaired and was dependent on staff with her transfers. R6's Restorative assessment dated [DATE] said she required the use of a mechanical lift with a 2-person assist with her transfers. R6's Fall Risk assessment dated [DATE] said she had a history of falls and was at a high risk for falls. On 4/14/2026 at 3 PM, R6 was sitting in her wheelchair at the nurse's station. V19 (RN) said R6 was a high risk for falls and had to be monitored when up in her wheelchair. R6 had a mechanical lift sling underneath her and was sitting on a pommel (wedged) cushion. The cushion was worn down, and the front edge curved down and under the wheelchair's seat and not properly placed in the wheelchair.On 4/15/2026 at 11:30 AM, V21 (Dialysis Nurse) said R6's dialysis treatment was completed, and she had to be transferred into her wheelchair. R6's wheelchair was in the dialysis room, and there was a mechanical lift sling on top of the seat. V21 said V25 (CNA) had transferred R6's into the dialysis chair in the morning by himself in the dialysis room. At 11:40 AM, V25 said he transferred R6 by himself (1-person assist) because her assigned agency CNA was not scheduled to arrive until later. On 4/17/2026 at 1 PM, V3 (Restorative/Fall Nurse) said R6 had a history of multiple falls, and on 1/26/2026, she fell near the nurses' station. V3 said R6's current fall prevention cushion (pommel) was in place during her fall. V3 continued to say that staff should transfer residents based on their plan of care, and R6 required the use of a mechanical lift for safe transfers because her level of function varied due to her dialysis treatment.R6's unwitnessed fall incident dated 1/26/2026 said she fell at 2:57 PM down the hallway near the nurses' station. R6 was observed sitting on the floor with her back resting on her wheelchair. R6 was unable to describe what had occurred due to her confusion.On 4/17/2026 at 12 PM, V4 (Therapy Director) said R6 was being treated by therapy for general weakness. V4 said therapy had also made prior recommendations to the nursing team to ensure R6's was properly seated in her wheelchair to ensure proper sitting posture and placement of her cushion on the wheelchair because she had the tendency to lean forward and was at high risk for falls.R6's therapy communication sheets dated 2/19/2026, 3/23/2026, and 3/25/2026, said they recommended she be properly positioned in her wheelchair to ensure proper safe posture when up in her wheelchair.R6's fall care plan included multiple interventions, including the use of her pommel cushion (safety device), and need to be monitored at the nurses' station due to her high risk for falls.4. R5's fall care plan said she was admitted on [DATE] and was at high risk for falls due to her medical history. R5's care plan had multiple interventions, including the use of a floor mat when in bed.On 4/14/2026 at 11:20 AM, R5 was in bed, and her fall mat was not in place. The blue fall mat was in an upright position next to her chair across her bed. R5 was anxious at times and showed signs of impaired memory. R5 said she had recently fallen and broken her left hip. At 11:25 AM, V13 (Agency CNA) entered R5's room to offer her water. When V13 left the room, he failed to implement R5's fall mat intervention. Then, at 11:40 AM, V14 and V15 (CNAs) also failed to implement R5's fall mat intervention after they assisted her with her toileting needs in bed.The facility's Fall Occurrence policy, dated 6/30/2025, said it was the policy of the facility to ensure that residents were assessed for their risk for falls, that interventions were put in place, and that interventions were reevaluated and revised as necessary. The policy said those identified as high risk for falls would be provided with fall interventions. The Falls Coordinator will review the incident reports and conduct his/her own fall investigation to determine the reasonable cause of a fall. The nurse may immediately start interventions to address falls in the unit, even prior to the Falls Coordinator's investigation. But (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ultimately, the Falls Coordinator may change the interventions provided by the nurse if his/her investigation identifies a more appropriate intervention for the individual's fall. The Falls Coordinator will add the interventions in the resident's care plan, and the interventions will be reevaluated and revised as necessary.