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	04/24/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, and record review the facility failed to ensure a resident was free from significant medication errors. This applies to 1 of 3 residents (R1) reviewed for medications in the sample of 4. The findings include: On 4/23/26 at 9:37 AM, R1 was observed in her room lying in bed. R1 said she does not receive all her medications. They run out of my medications. R1 said she did not receive her pain patch (Fentanyl) and blood thinner injection (Lovenox) a few weeks ago. Nursing said they didn't have the medication. R1 said there's medication issues every month.R1's Medication Administration Record (MAR) dated April 2026 shows orders including Lovenox 40 mg (milligrams) inject 40 mg every twelve hours. R1's MAR shows Lovenox 40 mg was not administered for five doses. R1's MAR on 4/10 and 4/22 shows there was no documentation of the medication administered. R1's MAR shows on 4/7, 4/8, 4/11, the medication was unavailable and not administered. R1's MAR dated April 2026 shows orders including Fentanyl transdermal patch every 72 hours 50 mcg/hr (micrograms) apply one patch transdermally every 72 hours for pain. On 4/10/26, R1's fentanyl patch was unavailable and not administered. On 4/23/26 at 11:13 AM, V2 (DON/Director of Nursing) said when the medication is running low nursing should order at minimum three days in advance. Some medication we can pull from our emergency supply if the medication is not available. If the medication is not documented on the M.A.R it was not administered. V2 said there was a time when R1 did not receive her blood thinner injection because the agency nurse said she could not find it. V2 said she was not aware of any other missed doses. On 4/23/26 at 12:46 PM, V3 (ADON/Assistant DON) reviewed R1's April 2026 MAR with this surveyor and confirmed R1 did not receive her fentanyl patch on 4/4/26. V3 said the patch was ordered through pharmacy but it was not available to administer. V3 said medications should be signed off when administered. V3 said R1's blood thinner injection medication is delivered in a box supply. There should be plenty of supply for nursing to administer the medication. She is not sure why nursing is documenting unavailable. The facility's Medication Administration Policy dated 4/2026 states, To ensure that the administration of medications is performed in a safe manner to prevent medications errors.at completion of med pass, review all EMARs to assure all medications have been administered and documented.

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