STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145665	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpine Care of Zion	2534 Elim Avenue Zion, IL 60099

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that residents were free from physical abuse, including residents who have a history of resident-to-resident physical altercations. This applies to 2 of 4 residents (R1 & R2) reviewed for physical abuse in the sample of 4. The findings include:R1's face sheet lists her diagnoses to include: schizoaffective disorder, bipolar type, major depressive disorder, anxiety disorder and post-traumatic stress disorder. R2's face sheet lists his diagnoses to include: alcohol abuse, cocaine abuse and generalized anxiety disorder. On 4/13/26 at 9:58 AM, R2 stated, (on 3/31/26) he was on the elevator trying to go to the 4th floor when R1 tried to get on the elevator with him. He told her there wasn't enough room for her on the elevator. She got mad and forced her way onto the elevator running over his foot with her wheelchair. He couldn't get out and had to call for help. V5 Activity Aide heard him calling for help and came over to help. She was able to move R1 out of the way so R2 could get out. They both went on with their day. Later that same day, R1 called the police and stated, R2 hit her and broke her arm. He stated, he never hit her, she ran over his foot and wouldn't let him leave the elevator. His foot was sore for a few days and they did an x-ray to make sure everything was ok. The x-ray was negative. This is also not the first time they had gotten into it and R1 accused him of hitting her. The facility found that was not true.On 4/13/26 at 3:05 PM, R1 stated, (on 3/31/26) she was trying to get on the elevator with R2 when he started yelling at her and hit her with his walker. He hit her on top of her shoulder. She called the police but they sided with him. She did go to the hospital and had a bruise. This is not the first time they have gotten into it. He ran over her foot one time. The facility's final incident investigation form dated 4/8/26 shows, resident to resident altercation. Circumstances of the alleged incident: R1 reported to V3 Social Services, that R2 while on the elevator hit her in the arm and ran over her foot with his rollator/walker. R2 stated, that R1 backed up into the elevator with her wheelchair and ran over his foot and then would not let him exit the elevator. V5 Activity Aide came to the elevator and helped to separate them. R1 called the police herself. R1 demanded to go to the hospital and was sent out to local hospital. All x-rays were negative. R2 refused to go to the hospital. The facility's employee/resident statement/interview form dated 3/31/26 written by V8 Licensed Practical Nurse (LPN) shows, Statement: Around 12:30 (PM) this afternoon, resident (R2) was on the elevator going from floor 1 to the penthouse. Elevator stopped on the third floor and a female resident (R1) attempted to enter the elevator. Upon entrance of the elevator, female resident (R1) (accompanied with wheelchair) rolled into the residents (R2) foot and walker, cornering him. Elevator closed and went to penthouse. Female resident (R1) noted to yell at resident A (R2), verbalizing she can be on the elevator with him. Once elevator reached penthouse, resident A (R2) expressed to female resident (R1) that he would like to exit, in which the female resident (R1) refused access to resident A (R2) to exit. Resident A (R2) called out for help, when a staff member (V5 activity aide) came and requested the female resident (R1) to allow resident A to exit elevator in which she refused. Staff member assisted female resident (R1) out of elevator, allowing resident A (R2) to exit on the penthouse floor. Female resident (R1) re-entered elevator going down. On 4/13/26 at 11:37 AM, V5 Activity Aide (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated, she was on her way to the bathroom when she heard R2 calling for help to get off the elevator. She asked R1 to move out of the way and she refused to move. She ended up helping R1 move so R2 could get off the elevator. R1 was being a little difficult and was upset. R1's behavior progress notes dated 3/31/26 shows, Behavior: Resident called the police on another resident (R2) today, which is an identified characteristic noted on her care plan. Seeking out, bullying, and fabricating information about another resident, stating they displayed negative towards her. Non-Pharmacological Interventions: Resident requested to be sent to hospital complaining of pain her arm and foot. Resident transported via ambulance to local hospital for further evaluation.R1's local hospital discharge instruction dated 3/31/26 shows, Diagnosis: 1: contusion of right shoulder; 2: contusion of left foot. Education: Contusion: A contusion is a deep bruise. Contusions are the result of a blunt injury to tissues and muscle fibers under the skin. R2's change of condition progress note dated 3/31/26 shows, At around 1730 (5:30 PM) resident reported to writer that his r (right) foot was ran over with a wheelchair and he is experiencing soreness, writer assessed residents' foot no signs of swelling or redness at this time. Recommendations of Primary Clinicians: NP (nurse practitioner) instructed writer to place order for x-ray of the R foot. R2's x-ray of the right foot results dated 4/1/26 shows, There is no acute fracture, dislocation. R1's Minimum Data Set, dated [DATE] shows, she is cognitively intact. R2's Minimum Data Set, dated [DATE] shows, he is cognitively intact. On 4/13/26 at 11:00 AM, V3 Social Services stated, R1 and R2 have issues with each other. More R1 than R2. No one understands why she has it out for him or why she keeps trying to get him in trouble. There have been two incidents between the two now. The first one R1 said R2 rolled over foot. They were able to check the cameras and found that was not true. The facility's concern/response form dated 3/9/26 from R1 about R2 shows, a concern with a resident behavior/interaction/roommates. Resident (R1) reports that she was involved in a verbal disagreement with another resident (R2). Follow up action taken: Based on staff observation and assessment no physical altercation or contact was observed on camera footage. Situation appeared to be a verbal disagreement between residents that escalated due to misunderstanding.Follow up Action Taken: Staff reinforced maintaining respectful interactions. Staff will monitor interactions to prevent further escalation On 4/13/26 at 2:30 PM, V2 Director of Nursing stated, she knows R1 and R2 have personality conflicts and don't like each other. They don't get along. The facility's abuse and retaliation policy dated 1/29/26 shows, Policy Statement: It is the policy of the facility to provide professional care and services in an environment that is free form any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment. The facility follows the federal guidelines dedicated to prevention of abuse and timely and seven (7) federal components of prevention and investigation. Definitions of abuse, neglect, exploitation & abuse coordinator: Abuse: Abuse is willful infliction of mistreatment, injury, unreasonable confinement, intimidation or punishment. Abuse assumes intent to harm, but inadvertent or careless behavior done deliberately that results in harm may be considered abuse. Types of abuse: 1. Physical, 2. Verbal, 3. Mental, 4. Sexual, 5. Neglect, 6. Theft/Misappropriation of property/financial abuse, 7. Involuntary seclusion, 8. Exploitation, 9. Injury of Unknown Origin, 10, Retaliation. Types of abuse and examples: 1. Physical: Physical abuse includes but is not limited to infliction of injury that occur other than by accidental means and requires medical attention. Examples: hitting, slapping, kicking, squeezing, grabbing, pinching, punching, poking, twisting, and roughly handling. Any person in a position of power or authority may potentially cause harm to a resident. Potential aggressors include but are not limited to, facility staff, other residents, state employers, family members, volunteers, students in an affiliated Nurse-training program, students in affiliated institutions including therapy, social, and activity programs, guardian and other visitors.