

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055038		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/21/2026	
NAME OF PROVIDER OR SUPPLIER Alpine Care of St. Charles LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 611 ALLEN LANE , SAINT CHARLES, Illinois, 60174			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S0000	Initial Comments		S0000			03/22/2026	
	Complaint Investigation 2672834/2798042						
S9999	Final Observations		S9999			03/22/2026	
	Statement of Licensure Violations:						
	300.610a)						
	300.1010h)						
	300.1210b)						
	300.1210d)3)						
	Section 300.610 Resident Care Policies						
	a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.						
	Section 300.1010 Medical Care Policies						
	h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.						
	Section 300.1210 General Requirements for Nursing and Personal Care						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to notify the physician, document, and monitor a resident (R8) after an 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. 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			S9999			

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S9999	Continued from page 2 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		S9999				

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S9999	Continued from page 3 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 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			S9999			

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S9999	Continued from page 4 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 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. 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." (A)		S9999				