STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145670	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chalet Living & Rehab	7350 North Sheridan Road Chicago, IL 60626

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 45196 Based on observation, interview, and record review, the facility failed to update a resident's care plan that was high risk for falls to include fall prevention interventions after a fall for one resident (R1) out of 3 residents reviewed for fall prevention. Findings include: R1's face sheet documents that R1 has the following medical diagnosis including but not limited to other lack of coordination, chronic obstructive pulmonary disease with (acute) exacerbation, plantar fascial fibromatosis, corns and callosities, generalized anxiety disorder, and post-traumatic stress disorder. R1's Minimum Data Set (MDS) dated [DATE] shows that R1 has a Brief Interview for Mental Status (BIMS) score of 15 which indicates that R1 is cognitively intact. On 05/06/24 at 12:14 pm, R1 was observed ambulating in R1's room into the hallway without assistance and with an unsteady gait. R1 stated, I (R1) keep falling at the facility and nothing is being done about it. R1 would not stop to speak with Surveyor and Surveyor was not able to ask R1 questions. R1 ambulated down the hallway stating, They are trying to keep me in a wheelchair, but I (R1) won't let them do it. On 05/06/24 at 12:15 pm, V7 (Registered Nurse/RN) stated that V7 is R1's nurse every day at the facility. When V7 was asked regarding R1 falling at the facility V7 stated that R1's last fall was a few months ago at the facility and that R1 is a fall risk. V7 stated that V7 recalls R1's last fall a few months ago when V7 observed R1 sitting on the floor in the hallway outside of R1's room. V7 stated that V7 did not observe R1 with any injuries, R1 denied hitting R1's head and that R1 was not sent to the local hospital for an evaluation. When V7 was asked regarding R1's fall interventions at the facility that were implemented after R1's fall on 02/17/24, V7 stated, R1 does not have fall interventions because R1 does not fall a lot at the facility. (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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(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 - Few	On 05/07/24 at 1:07 pm, V2 (Director of Nursing/DON) stated that V2 does not interact with R1 due to R1's preference. V2 stated that R1's last fall at the facility was on 02/17/24 when R1 was found sitting on the floor outside of R1's room. V2 explained that R1 was assessed without injury and was not sent to the local hospital due to the fall. When V2 was asked regarding R1's fall interventions implemented from R1's fall on 02/17/24. V2 stated, I (V2) don't see any interventions that were placed for R1's fall on 02/17/24. Can you ask V13 (Falls Nurse, License Practical Nurse). She (V13) is the one responsible for implementing fall interventions after a resident has a fall. When V2 was asked regarding when are fall interventions put into place for residents, V2 stated, After a resident has a fall occurrence. When V2 was asked regarding the importance of residents having fall interventions implemented after a fall occurrence V2 stated, So the resident does not have another fall. On 05/07/24 at 2:11 pm, V13 (Falls Nurse, Licensed Practical Nurse) stated that R1 sustain a fall prior to V13 coming into work on 02/17/24. V13 stated that V13 forgot to document and implement fall interventions for R1's fall occurrence on 02/17/24. V13 then explained when V13 spoke with R1 regarding R1's fall on 02/17/24, R1 began denying falling or having any injuries and that V13 discussed fall interventions with R1 such as staying in bed when R1 feels tired and to use the call light for help. V13 then stated that after V13 discussed fall interventions with R1, V13 got busy and forgot to update R1's care plan with fall interventions for R1's fall occurrence on 02/17/24. When V13 was asked regarding the importance of fall interventions to be updated on a resident's care plan after a resident has a fall occurrence V13 stated. So, the resident can be monitored, and the incident does not occur again. R1's progress note dated 02/17/24 at 9:44 am, authored by V7 (Registered Nurse) documents, in part that V7 noted R1 in a sitting position on the floor outside of R1's room. The facility's document dated 02/17/24 and titled Falls Without shows that R1 had a fall occurrence on 02/17/24. R1's fall care plan dated 08/11/23 documents, in part: Focus: R1 is at risk for falls related to unsteady gait. No interventions documented for R1's fall occurrence on 02/17/24. R1's fall risk evaluation dated 09/12/23 shows that R1 has a score of 11 which indicates that R1 is high risk for falls. R1's fall risk evaluation dated 02/17/24 shows that R1 has a score of 12 which indicates that R1 is high risk for falls. The facility document dated 07/17/23 and titled Fall Occurrence documents, in part: Policy Statement: It is the policy of the facility to ensure that residents are assessed for risk for falls, that interventions are put in place, and interventions are reevaluated and revised as necessary. Procedure: . 2. Those identified as high risk for falls will be provided fall interventions . The Falls Coordinator will add the intervention in the residents' care plan.