

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145670	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2024
NAME OF PROVIDER OR SUPPLIER Chalet Living & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45002</p> <p>Based on interview and review of record, facility failed to follow their policy to ensure residents would be free from abuse and mistreatment for two (R2 and R3) out of three residents reviewed for abuse. R2 expressed feelings of hurt and frustration.</p> <p>Findings include:</p> <p>R2's Face sheet documents in part: R2's diagnosis are traumatic brain injury, anoxic brain damage, generalized epilepsy, and epileptic syndrome, MERRF (Myoclonic epilepsy with ragged red fibers) syndrome, schizoaffective disorders, bipolar disorder, cerebellar ataxia.</p> <p>R2's MDS (minimum data set) section C (05/22/2024) documents in part: R2's BIMS (Brief Interview for Mental Status) score is 15 which means R2 is cognitively intact.</p> <p>R3's MDS Section C documents in part: R3's BIMS score is a 15 which means R3 is cognitively intact.</p> <p>On 06/12/2024 at 11:52 AM, surveyor saw R2 sitting in his room in a wheelchair. R2 had mild tremors and would have difficulty formulating his words. Surveyor observed a CNA (Certified Nursing Assistant) feeding R2. R2 stated he needs help feeding because he cannot feed himself. R2 stated that a couple weeks ago, he requested to be fed late at night. He asked V9 (CNA) to feed him because he could feed himself. R2 stated that V9 said she will feed him when she [NAME] up. R2 then stated that V9 came to feed him and when she was feeding him, V9 would deliberately throw spaghetti at him while feeding him. R2 stated that the spaghetti fell all over his face and his shirt. R2 stated that he felt very hurt when she did that. R2 stated that he went to V3 (Licensed Practical Nurse/LPN) to tell her about the situation and that he wants to speak to V10 (Nurse Supervisor). R2 stated that V10 nor anyone else has come to talk to him about the situation. R2 stated that V3 said to him forget it. I will feed you. R2 stated that he wanted to speak to the V10 (Nurse supervisor) but V10 never came and spoke to him because V3 never relayed the incident to V10.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/12/2024 at 11:52 AM, surveyor saw R3 sitting on his bed in his room. R3 stated that the morning CNAs are great and helpful and that the evening and night CNAs are awful. R3 stated that they have so much attitude, they don't help. R3 stated that he is the one emptying his roommates' urinals. R3 stated that they just don't want to take care of you. They swear at me all the time. R3 stated that the CNAs are actually really mean to R2. They get food on him, swear at him. I saw some CNAs while feeding him, throw food at him and then giggle about it. R3 stated that R2 doesn't want those CNAs taking care of him but he is stuck with them. R3 stated that he has seen them throw food at him and R2 has told him about the situation. They tell me to leave but I stand my ground and say no, I want to know what's going on here and how they treat him.</p> <p>On 06/14/2024 at 11:30 AM, R4 stated that he has seen CNAs yell and swear at other residents.</p> <p>On 06/12/2024 at 1:41 PM, V3 (LPN) stated that she has been working for about three months. V3 stated that she works 3:00 PM to 11:00 PM on the 2nd floor. V3 stated that she usually works with residents in room XXX through YYY. V3 stated that she is familiar with R2. V3 stated that R2 has issues with so many CNAs. V3 stated that sometimes the CNAs do not want to feed him because he eats dinner late night around 9:00 PM and during that time CNAs are caring and cleaning up other residents. V3 stated that R2 usually wants to be fed at that moment but the CNA will tell him that they will come feed him after they are done with what they are doing at that moment. So, it is usually an issue because he gets very angry if they do not feed him when he wants to be fed. V3 stated that she witnessed the rift between R2 and V9 (Certified Nursing Assistant) a few months ago. V3 explained by saying that R2 wanted to eat again after dinner but V9 was with another resident. V3 stated that V9 asked R2 to wait but he would not take no for an answer, and they started arguing back and forth but eventually V9 fed him. And I heard V9 (CNA) get angry and fed him. V3 stated that she called the DON (Director of Nursing) and told him how R2 is demanding to get fed at night while other CNAs are busy and how V9 got upset. V3 stated that V9 did not swear or yell at him. V3 stated that the most recent incident was when R2 complained to her about how some spaghetti fell on his shirt while V9 was feeding him. He asked V9 to leave his room and then I went into his room to feed him. That day I did not tell anybody. V3 stated that R2 told her that, a lady CNA was feeding him, and she tried to throw food at him. R2 rolled up to her in his wheelchair at the nurse's station and showed her his shirt and said, Can you see how she fed me? She is throwing food at me and not feeding me well . V3 stated that then she called V9 and asked her if she threw food at R2. She said no. V3 stated that this incident she did not tell anybody. Maybe I was supposed to tell somebody, in retrospect I should have but I was new and did not think to. V3 stated that the first incident happened April or March with V9. The incident with the food happened a month ago.</p> <p>On 06/13/2024 at 12:30 PM, V1 (Administrator) stated that he was not aware of this situation. V1 stated that V11 (Interim Administrator) filed an initial report yesterday. We tried to interview R3, but he got picked up by the FBI (Federal Bureau of Investigation) this morning. So, we haven't been able to talk to him. V1 stated that we started the investigation. Based on what we have found so far, we do not think it is abuse. R2 is known to always come to talk to me when something upsets him. V1 stated that R2 is known to make an issue bigger than it is also make false accusations against people when things bother him. This is documented in his care plan. V1 stated that he checked with the dietary manager and that the facility served spaghetti only once last month and that day, V9 and V10 were not working. After speaking to V3, we do not even know who the perpetrator might be. V1 stated that he spoke to V9 and V10 about this incident and they said nothing happened. V1 stated that they are still working on the investigation.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/13/2024 at 2:08 PM, V10 (Nurse Supervisor) stated that he has been working at the facility for [AGE] years. V10 stated that he monitors all the floors from 3pm to 11 pm. V10 stated that generally R2 did not provide a serious complaint. If anything, he complained about medication or assisting if he can go to bed and maybe smoke. V10 stated that no nurse reported anything to him about any incidences between R2 and any CNAs. V10 stated that he has not seen any CNAs be rude in any way to R2. V10 stated that staff members are supposed to report to himself when DON or administrator is not around about any abuse allegations.</p> <p>On 06/25/2024 at 10:07 AM, V2 (DON) stated that he has been working here for 7 years. V2 stated he is familiar with V9 and V10 (CNA). V2 stated that no one has complained to him about his CNAs. It is expected that all staff members are to report any allegation of abuse to the administrator right away. V2 stated that R2 needs help showering. One his scheduled days, the CNAs offer a shower but there are times when he refused and then they would just document it that he refused shower. V2 stated that R2 needs help feeding. V2 stated that sometimes he orders food from outside and if it is something that doesn't spill, he will try to feed himself but if his food is something that spills, he will ask to feed himself. V2 stated that V3 never told him about any incidents that took place between V9 and R2. V2 stated that R2 has never complained to him about the care he has been receiving here at the facility. V2 stated no one has complained to him about CNAs' being too rough when they are cleaning them and changing them. V2 stated that he never asked V3 what had happened between R2, V3 and V9.</p> <p>On 06/25/2024 at 10:17 AM, V9 (CNA) stated that she has been working at this facility from April of 2024. V9 stated that he works on the 2nd floor usually. V2 stated that he has worked with R2, but it has been about three months now. V9 stated that R2 is a feeder. V9 stated that there never was a time when we yelled at each other. V9 stated that there wasn't a time when he spilled food on his shirt. He goes to the bathroom and when he finishes, he calls you to clean him up. V9 stated that he is not rough when he cleans R2. V9 stated that no one has complained about being too rough when he cleans them.</p> <p>On 06/25/2024 at 10:37 AM, V10 (CNA) stated that she has been working at the facility for 6-7 months. V10 stated that she normally works on the 2nd floor. V10 stated that she has worked with R2. V10 stated she has switched working with R2 with another CNA. V10 stated that R2 doesn't want V10 working with him. V10 stated she doesn't know why R2 refuses V10 to work with him. V10 stated that R2 needs help with feeding. V10 stated that she has never fed R2 ever since she has been working with him. V10 stated that she has not seen R2 get into arguments with other CNAs. V10 also stated R2 has never complained to her about how another CNA feeds or cleans him up. V10 stated that if she sees another CNA yell and argue with a resident, she is expected to separate them and report the incident to their immediate supervisor. V10 stated no resident has complained about her being too rough when she cleans them up. V10 stated that she has never seen any CNA feed R2 inappropriately.</p> <p>Per the interview, V1 and V2 were not aware of the abuse allegation until the surveyor brought it to their attention.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R2's Abuse Report Final Form (6/18/2024) documents in part: V3 said that R2 had one piece of spaghetti on his shirt. This does not constitute abuse. R2 said to her, Look at how they feed me. The logic explanation is that the other CNA that had been feeding R2, spilled a noodle on his shirt while trying to feed him. R2 got upset and wheeled himself into the hall to find V3 and complain about that. Based off resident continuing to change account of the story the facility finds no evidence of abuse.</p> <p>Facility Abuse policy (7/14/2023) documents in part: It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment. Abuse is the 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. Verbal abuse includes but not limited to the use of oral, written or gestured language. If abuse is suspected, the facility will separate the alleged abuser from the resident. Mental abuse includes but is not limited to humiliation, harassment, threat of bodily harm, punishment, isolation (involuntary, imposed seclusion), or deprivation to provoke fear of shame.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45002</p> <p>Based on interview and record review, failed to follow their policy to report an allegation of abuse to the administrator or administrator's designee for two residents (R2 and R3) out of three residents reviewed for abuse.</p> <p>Findings include:</p> <p>R2's Face sheet documents in part: R2's diagnosis are traumatic brain injury, anoxic brain damage, generalized epilepsy, and epileptic syndrome, MERRF (Myoclonic epilepsy with ragged red fibers) syndrome, schizoaffective disorders, bipolar disorder, cerebellar ataxia.</p> <p>R2's MDS (minimum data set) section C (05/22/2024) documents in part: R2's BIMS (Brief Interview for Mental Status) score is 15 which means R2 is cognitively intact.</p> <p>R3's MDS Section C documents in part: R3's BIMS score is a 15 which means R3 is cognitively intact.</p> <p>On 06/12/2024 at 11:52 AM, surveyor saw R2 sitting in his room in a wheelchair. R2 had mild tremors and would have difficulty formulating his words. Surveyor observed a CNA (Certified Nursing Assistant) feeding R2. R2 stated he needs help feeding because he cannot feed himself. R2 stated that a couple weeks ago, he requested to be fed late at night. He asked V9 (CNA) to feed him because he could feed himself. R2 stated that V9 said she will feed him when she [NAME] up. R2 then stated that V9 came to feed him and when she was feeding him, V9 would deliberately throw spaghetti at him while feeding him. R2 stated that the spaghetti fell all over his face and his shirt. R2 stated that he felt very hurt when she did that. R2 stated that he went to V3 (Licensed Practical Nurse/LPN) to tell her about the situation and that he wants to speak to V10 (Nurse Supervisor). R2 stated that V10 nor anyone else has come to talk to him about the situation. R2 stated that V3 said to him forget it. I will feed you. R2 stated that he wanted to speak to the V10 (Nurse supervisor) but V10 never came and spoke to him because V3 never relayed the incident to V10.</p> <p>On 06/12/2024 at 11:52 AM, surveyor saw R3 sitting on his bed in his room. R3 stated that the morning CNAs are great and helpful and that that the evening and night CNAs are awful. R3 stated that they have so much attitude, they don't help. R3 stated that he is the one emptying his roommates' urinals. R3 stated that they just don't want to take care of you. They swear at me all the time. R3 stated that the CNAs are actually really mean to R2. They get food on him, swear at him. I saw some CNAs while feeding him, throw food at him and then giggle about it. R3 stated that R2 doesn't want those CNAs taking care of him but he is stuck with them. R3 stated that he has seen them throw food at him and R2 has told him about the situation. They tell me to leave but I stand my ground and say no, I want to know what's going on here and how they treat him.</p> <p>On 06/14/2024 at 11:30 AM, R4 stated that he has seen CNAs yell and swear at other residents.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/12/2024 at 1:41 PM, V3 (LPN) stated that she has been working for about three months. V3 stated that she works 3:00 PM to 11:00 PM on the 2nd floor. V3 stated that she usually works with residents in room XXX through XYY. V3 stated that she is familiar with R2. V3 stated that R2 has issues with so many CNAs. V3 stated that sometimes the CNAs do not want to feed him because he eats dinner late night around 9:00 PM and during that time CNAs are caring and cleaning up other residents. V3 stated that R2 usually wants to be fed at that moment but the CNA will tell him that they will come feed him after they are done with what they are doing at that moment. So, it is usually an issue because he gets very angry if they do not feed him when he wants to be fed. V3 stated that she witnessed the rift between R2 and V9 (Certified Nursing Assistant) a few months ago. V3 explained by saying that R2 wanted to eat again after dinner but V9 was with another resident. V3 stated that V9 asked R2 to wait but he would not take no for answer, and they started arguing back and forth but eventually V9 fed him. And I heard V9 (CNA) get angry and fed him. V3 stated that she called the DON (Director of Nursing) and told him how R2 is demanding to get fed at night while other CNAs are busy and how V9 got upset. V3 stated that V9 did not swear or yell at him. V3 stated that the most recent incident was when R2 complained to her about how some spaghetti fell on his shirt while V9 was feeding him. He asked V9 to leave his room and then I went into his room to feed him. That day I did not tell anybody. V3 stated that R2 told her that, a lady CNA was feeding him, and she tried to throw food at him. R2 rolled up to her in his wheelchair at the nurse's station and showed her his shirt and said, Can you see how she fed me? She is throwing food at me and not feeding me well. V3 stated that then she called V9 and asked her if she threw food at R2. She said no. V3 stated that this incident she did not tell anybody. Maybe I was supposed to tell somebody, in retrospect I should have but I was new and did not think to. V3 stated that the first incident happened April or March with V9. The incident with the food happened a month ago.</p> <p>On 06/12/2024 at 1:45 PM, V11 (Interim Administrator) stated he submitted the initial report to the state surveying agency. V11 stated that he doesn't know why V3 did not notify anyone. She knows that she is expected to report any allegations of abuse to the administrator or the responsible designee. We will begin this investigation right away.</p> <p>On 06/13/2024, and 12:30 PM, V1 (Administrator) stated that he was not aware of this situation. V1 stated that V11 (Interim Administrator) filed an initial report yesterday. V1 stated that V3 should have mentioned it to me, or V10 but she didn't report it because she didn't think it was abuse.</p> <p>On 06/13/2024 at 2:08 PM, V10 (Nurse Supervisor) stated that he has been working at the facility for [AGE] years. V10 stated that he monitors all the floors from 3pm to 11 pm. V10 stated that generally R2 did not provide a serious complaint. If anything, he complained about medication or assisting if he can go to bed and maybe smoke. V10 stated that no nurse reported anything to him about any incidences between R2 and any CNAs. V10 stated that he has not seen any CNAs be rude in any way to R2. V10 stated that staff members are supposed to report to himself when DON or administrator is not around about any abuse allegations.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/25/2024 at 10:07 AM, V2 (Director of Nursing) stated that he has been working here for 7 years. V2 stated he is familiar with V9 and V10 (CNA). V2 stated that no one has complained to him about his CNAs. It is expected that all staff members are to report any allegation of abuse to the administrator right away. V2 stated that V3 never told him about any incidents that took place between V9 and R2. V2 stated that R2 has never complained to him about the care he has been receiving here at the facility. V2 stated no one has complained to him about CNAs' being too rough when they are cleaning them and changing them. V2 stated that he never asked V3 what had happened between R2, V3 and V9.</p> <p>Per the interview, V1 and V2 were not aware of the abuse allegation until the surveyor brought it to their attention.</p> <p>Fax to the state surveying agency Facility Reported Incidents documents in part: R2's Abuse Report Initial Form sent to the state surveying agency on 06/12/2024.</p> <p>Facility Abuse policy (7/14/2023) documents in part: All allegation and/or suspicion of abuse must be reported to the Administrator immediately. If the administrator is not present, the report must be made to the administrator's designee. All allegation of abuse will be reported to (the state surveying agency) immediately not exceeding two hours after initial allegation is received. If abuse is suspected the facility will notify the appropriate/designated organization/authority (the state surveying agency) than an investigation is being initiated immediately following interventions for the resident's safety.</p>