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	03/25/2025

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 - Immediate jeopardy to resident health or safety 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** 15301 Based on interview and record review, the facility failed to supervise, monitor, and develop an effective plan to prevent residents with known histories of substance abuse from obtaining illicit drugs while in the facility for three of three residents (R1, R4, R5) reviewed for opioid use. These failures resulted in R1, R4, and R5 obtaining illicit drugs and having suspected overdoses while not being able to leave the facility on pass. R1, R4, and R5 did not leave the facility, nor did they have community passes in their care plans. Findings include: R1 experienced a suspected opioid overdose on 1/17/25, requiring administration of Narcan (medication used to reverse the effects of opioids) at the facility with evaluation and treatment in local emergency department. R4 experienced a suspected opioid overdose on 12/22/24 requiring evaluation and treatment in the local emergency department. R4 experienced a second suspected opioid overdose on 1/17/25, requiring administration of Narcan. R5 was sent to the local hospital for evaluation of seizure activity on 2/5/25. R5 required urgent endotracheal intubation (inserting a tube into the windpipe) for airway protection; used syringe was found at R5's bedside. The immediate jeopardy began on 12/22/24, when R4 had a suspected opioid overdose. The Administrator, Assistant Administrator, Director of Nursing, and Nurse Consultant were notified of the immediate jeopardy on 3/13/25 at 12:24 PM. An abatement plan was provided on 3/17/25 at 4:52 PM. This plan was sent back for corrections. An abatement plan was provided on 3/18/25 at 1:54 PM. This plan was sent back for corrections. An abatement plan was provided on 3/19/25 at 1:21 PM. This plan was returned for corrections. An abatement plan was provided on 3/19/25 at 8:32 PM. This plan was sent back for corrections. An abatement plan was received on 3/20/25 at 2:43 PM. This plan was sent back for corrections. (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: 145670	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/25/2025
NAME OF PROVIDER OR SUPPLIER: Chalet Living & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE: 7350 North Sheridan Road, Chicago, IL 60626	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An abatement plan was received on 3/20/25 at 3:15 PM. This plan was sent back for corrections. An abatement plan was received on 3/20/25 at 3:48 PM. This abatement plan was accepted on 3/20/25 at 3:50 PM. Based on observation, interview, and record review, the immediacy was removed on 3/20/25. Although the immediacy was removed, the facility remains out of compliance at severity level II until the facility can evaluate the effectiveness of the removal plan and maintain substantial compliance with this regulation. 1). R1's medical record (Face Sheet) documents R1 is a [AGE] year-old admitted to the facility on [DATE] with diagnoses including but not limited to: (Idiopathic) Normal Pressure Hydrocephalus, Opioid Abuse, Uncomplicated; Nicotine Dependence, Unspecified, Uncomplicated; and Post Traumatic Stress Disorder, Chronic. R1's MDS (Minimum Data Set, 12/9/24) documents a BIMS (Brief Interview for Mental Status) of 12 indicating moderate cognitive impairment. On 1/17/25 at 8:58 PM, R1's progress note documents in part, the attention of the nurse was called by the assigned CNA (Certified Nursing Assistant) stating that the resident seems unresponsive when called by name. The resident was observed unresponsive with slow breathing, small, constricted pinpoint pupils. Due to history of opioid use, the resident seems to be exhibiting symptoms of opioid use. Two Narcan shots were given nasally. After 30 minutes, the resident became responsive. 911 was called and R1 was transferred to the (local hospital emergency department). On 1/17/25 at 9:24 PM, R1's emergency room record documents in part, patient brought in from nursing home via EMS (Emergency Medical Services), for altered mental status. Per EMS report patient was lethargic on arrival. Patient was given Narcan with prompt return to baseline and he was endorsing using heroin today. On 1/17/25 (no time) R1's ambulance run sheet documents in part, staff (nursing home) reports patient was noted lethargic and was given 4 mgs (milligrams) of Narcan with improvement back to baseline. Patient admits to getting heroin from a fell ow resident. On 1/17/25, facility's incident report documents in part, (R1) was observed unresponsive/suspected overdose. Two sprays of Narcan were given. Security searched the resident's room and found nothing. (R1) unable to go out on pass. The visitor logs were checked for three days, and no visitors were found. The resident said he bought a $20.00 bag of heroin but would not say where he got it from. On 2/28/25 at 12:16 PM, R1 observed awake/alert, reclining in recliner chair. R1 said he bought a $20.00 bag of heroin from R4 with money he received from his trust fund. R4 came to R1's room at night to give R1 the heroin. R1 said the last time he used heroin was about three weeks ago when he had to go to the hospital and then several weeks prior to that but he did not get ill the first time. R1 informed the surveyor that he would not have used heroin if he had received Suboxone (Buprenorphine/Naloxone-a medicine to treat dependence on opioid (narcotic) drugs such as heroin or morphine in drug addicts) and if programming for his drug abuse/use had been available to him. R1 said he does not go out on pass. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/26/25 at 12:52 PM via telephone, V8 (Registered Nurse/RN) said my two CNAs (Certified Nursing Assistants) called me to tell me that R1 was not responding. I went in there and called him by his name. He wasn't responding to verbal or tactile stimuli. I know he has history of drug abuse. I called my supervisor, V9 (Nursing Supervisor) and he did the same thing. V9 grabbed the crash cart, gave him a dose of Narcan, then a second dose of Narcan. He started to come back gradually. We called 911. Before they came, he was fully awake. He was telling 911 that he didn't want to go to the hospital. V9 asked him what happened. R1 said I don't know. I don't know. He would not tell me what he took. He had never done this before. He did receive Suboxone when he was first admitted in June 2024, and I can't say why it was discontinued. He doesn't get methadone. V8 stated we need to keep talking to him, to see what he's thinking about, to keep him from using again. On 3/4/2025, at 9:51 AM, V2 (Director of Nursing/DON) said, R1's Suboxone was discontinued on 12/12/2024. One of the nurses told me they could no longer get prescriptions for the medication. When R1 was admitted , the prescription was provided by a hospital physician and an outside pharmacy continued to supply. The pharmacy reached out to the hospital physician and was informed they would no longer prescribe the Suboxone. R1 had leftover Suboxone that the (Social Service Agency) was holding for him; they brought it to the facility. We reached out to V23 (R1's Physician/Medical Director), he said he would prescribe the Suboxone. Normally when they are discharged from the hospital a referral has been made for follow up with addiction clinic. I heard there was an insurance issue, I can't remember what the issue was. We haven't been able to find a clinic for him; we have been looking. If Suboxone was not continued, the resident might go through withdrawal. They would probably want to use (illicit drugs). They probably would use. On 3/4/25 at 12:58 PM via telephone, V23 (R1's Physician/Medical Director) said, I have written prescriptions for Suboxone. It's not my preference to prescribe Suboxone. I don't want to get involved. I told them (facility) they should send R1 to a clinic. On 3/4/25 at 1:54 PM via telephone, V21 (Hospital Liaison) I'm at the hospitals. I follow up on referrals. As long as we can accommodate their needs, we will take residents who have a history of substance abuse. I can't think of any recent residents who were not accepted for admission. We wouldn't accept residents who had recently used illicit drugs. We wouldn't accept someone who uses heroin. On 3/4/25 at 11:24 AM, V19 (Social Service Director) said, R1 does not go out to the addiction clinic. I haven't sent anything for him. Yes, he should go to addiction clinic as he has past substance abuse history. Order Review Report documents the following orders for R1: - Buprenorphine HCl-Naloxone HCl Sublingual Film 8-2 MG (milligrams), Give 1 film sublingually (under the tongue) every 12 hours for pain. Order date: 6/10/24. Start date: 6/12/24. End date: 6/19/24. -Buprenorphine HCl-Naloxone HCl Sublingual Film 8-2 MG, Give 1 film sublingually (under the tongue) every 12 hours for pain. Order date: 6/19/24. Start date: 6/19/24. End date: 12/12/24. -Naloxone HCl Nasal Liquid 4 MG/0.1ML (milliliter), One spray in both nostrils as needed for Opioid overdose. Order date: 6/10/24. Start date: 6/11/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Substance Abuse/Chemical Dependency Disorders care plan (initiated/created 6/22/24, revised 3/3/25) documents R1 has a history of substance abuse/chemical dependency. R1 has a history of opioid use. Goals include R1 will complete the first step of the Alcoholics Anonymous program by admitting that he is powerless over alcohol by the next review; will refrain from using non-prescribed substances through the next review; and will comply with the intake procedures of a substance abuse treatment program (i.e. hospital, clinic-based, mental health agency or Alcoholics Anonymous by the next care plan review. All goals revised 1/8/25). Interventions include, implement increasingly restrictive interventions in an effort to help the resident break the addictive cycle. Interventions may include supervision while in the community, restricted independent pass privileges, implementation of money guidance and budget controls to reduce/prevent access to substances; meet with the IDT (Interdisciplinary Team) to discuss the extent of the resident's illness. The physician may not consider a referral to the psychiatrist and/or write an order restricting pass privileges; present the resident with a list of substance abuse treatment programs. Confront the resident concerning the illness and the self-destructive path. Focus on getting past denial by reciting the facts associated with Alcoholism (i.e. Alcoholism is a disease which will end in death if it is not treated. A significant percentage of Alcoholics are able to enter treatment and gain sobriety. The first step is admitting that one is in fact, Alcoholic); provide leisure counseling to the resident to help him use free tine in productive, not destructive ways; and work with the resident to establish a verbal or written behavioral contract specifying what is and is not allowed. Make sure the resident is aware of rules prohibiting use of alcohol, illicit substances and intoxication. All interventions created on 6/22/24. Revisions were made on 3/3/25 after complaint investigation initiated on 2/21/25. History of substance abuse and R1 has overdosed in the past care plan (initiated/created 2/27/25). Goals include R1 will remain drug free and abide by facility smoking policies and procedures; will meet with the facility psychotherapist to express emotions and feelings. Initiated/created 2/27/25. Intervention includes work with the resident to develop long-term goals focused on maintaining sobriety, building healthy coping mechanisms, and avoiding situations that may trigger relapse. Initiated/created 2/27/25, after complaint investigation initiated on 2/21/25. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Substance Abuse/Opioid care plan (initiated/created 3/2/25) documents R1 has a history of improperly using and abusing substances. R1 has poorly developed the ability to control impulses. This has led R1 to engage in narcotic seeking behaviors that include drug abuse. Education has been provided on the negative effects that substance (abuse) has on health, mental health, and psychosocial well-being. Education has been provided on abstaining from using substance. A referral has been made to psychological services to address addictions with substance, underlying reasons for addiction and substance use, ineffective coping mechanisms, and to learn to engage in healthy activities and employ healthy strategies to better cope with stress and anxiety and to not return to using substance. Goals include R1 will be open-minded to interventions that promote abstinence for using substance, will refrain from using substance, and work with social services/psychotherapist to address substance use/abuse. Interventions include, establish a verbal or written behavioral agreement specifying what is and what is not allowed. Make sure R1 is aware of the rules prohibiting use of illicit substances; work with the interdisciplinary team to discuss the extent of my illness. Refer R1 to the psychiatrist and clinical psychologist as indicated; and approach R1 concerning his illness and the self-destructive path that he is on. Focus on getting him past denial by reciting the facts associated with substance abuse (i.e. substance abuse is a disease which will end in death if it is not treated and that a significant percentage of persons who abuse substance are able to enter treatment and gain sobriety. Encourage R1 to take the first steps by admitting that he is in fact a substance abuser so that he may get the help and assistance that he needs. All goals and interventions created 3/2/25, after complaint investigation initiated on 2/21/25. No care plan specifically addressing independent out on pass was found. 2). R4's medical record (Face Sheet) documents in part, R4 is a [AGE] year-old admitted to the facility on [DATE] with diagnoses including but not limited to: Cerebral Infarction Due to Embolism of Left Anterior Cerebral Artery, Opioid Abuse with Intoxication, Unspecified; Other Schizophrenia, and Other Bipolar Disorder. MDS (Minimum Data Set, 12/5/24) documents a BIMS (Brief Interview for Mental Status) of 9 indicating moderate cognitive impairment. On 12/23/24 at 12:02 AM, R4's progress note documents in part, writer was alerted by CNA (Certified Nursing Assistant) and resident('s) roommate that resident appeared to be shaking uncontrollably. Nurse immediately ran to resident's bedside and was noted to be extremely diaphoretic, with pinpoint pupils non-reactive to light and accommodation. Resident visually shaking and lethargic. R4 was going in and out of consciousness. R4 immediately stated, I didn't take anything! Vitals taken immediately and noted in (electronic medical record). V2 (Director of Nursing) and physician were contacted. The physician was phoned with a new order to send R4 out 911. R4 walked out with the fire department and EMT (Emergency Medical Services) to the (local hospital). On 12/22/24 at 11:37 PM, R4's emergency room record documents in part, per report given to RN (Registered Nurse), patient was using drugs at his nursing home, so they called EMS. He (patient) told EMS he was using a little bit of heroin. On 12/22/24, (no time), R4's ambulance run sheet documents in part, patient stated he was using heroin in his room when the nurse walked in. Patient states he's a habitual user and did not get to use much before he was caught. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/23/24, the facility's incident report documents resident (R4) was found shaking uncontrollably. At the time drugs were not suspected. When the resident returned it was noted that the hospital stated Narcan was used. Security was notified and searched his room for drugs. Visitor logs were checked, and no visitors were noted. Resident does not have OOP (out on pass) privileges. On 1/17/25 at 11:20 PM, R4's progress note documents in part, writer was alerted by CNA that (R1) was lying on the floor, observed with drug overdose. R4 was noted to be extremely diaphoretic, with (pinpoint) pupils non-reactive to light. Resident observed lethargic. Naloxone 4mg nasal spray was (given). (R1) (transferred) to bed. After 30 minutes, the resident was observed smoking in the bathroom. When staff asked him why his smoking in the bathroom, resident was very aggressive toward staff. V22 (R4's Former Physician) notify (notified) with order to (send) him to (local hospital) for further evaluation. On 1/18/25 at 8:00 AM, R4's progress note documents in part, (R1) had some behaviors on the previous shift (11:00 PM-7:00 AM). He was noted with some respiratory distress as a result of a drug overdose. V22 (R4's Former Physician) was notified with an order to petition (R4) to the local hospital. On 1/17/2025, facility's incident report documents resident (R4) was observed unresponsive/suspected overdose. Two sprays of Narcan were given. The resident was sent out to the hospital. V12 (Security Guard) searched the resident's room and found nothing. Resident was discharged from the hospital to another nursing home. Visitor logs were checked for (R4). There were no visitors for the resident. Resident did not have OOP (out on pass) privileges. On 1/19/2025, at 9:34 AM, R4's hospital record documents in part, (R4) is [AGE] years old with past medical history significant for cerebrovascular accident with some aphasia as residual with underlying schizophrenia and bipolar disorders and hypertension with history of cognitive communication deficits secondary to underlying stroke and history of alcohol abuse and narcotic abuse brought to the emergency room by ambulance for agitations and they wanted to be evaluated. Evidently patient had episode of unresponsiveness most likely secondary to narcotic overdose with good response to Narcan. Evidently patient has Narcan and medication list and patient has history of opioid overdose. Presence of Abuse and Neglect Factors care plan (created 10/2/24/revised 10/5/24) documents R4 presents with a difficult or troubled past secondary to severe mental illness. He presents with risk factors related to abuse and neglect, due to his psychiatric history and present mental health symptoms, and substance abuse history. Goals include R4 will remain safe, free of mistreatment through next review R4 will be treated with respect, dignity, and reside in the facility from of mistreatment. Interventions include but are not limited to review assessment information. Emphasize treatment of causal factors and/or interventions designed to moderate/reduce symptoms (male treatment of compulsive behavior, substance abuse, anger and mental heal issues available to R4, as indicated). All goals and interventions created on 10/2/24, revised on 10/5/24. No care plans specifically addressing R4's illicit drug use/abuse history or independent out on pass were found. On 2/28/25 at 11:25 AM, via telephone, R4 denied using or selling drugs while at facility. I did not receive counseling at facility, even if it was available, I wouldn't have been interested. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3) R5's medical record (Face Sheet) documents R5 is a [AGE] year-old admitted to the facility on [DATE], with diagnoses including but not limited to: Hypertensive Chronic Kidney Disease with Stage 1 Through Stage 4 Chronic Kidney Disease, or Unspecified Chronic Kidney Disease; Opioid Dependence with Intoxication, Uncomplicated; Acute Hepatitis C Without Hepatic Coma, and Adjustment Disorder. R5's MDS (Minimum Data Set, 11/18/24) documents a BIMS (Brief Interview for Mental Status) of 15 indicating intact cognitive function. On 2/5/25, at 10:03 AM, R5's progress note documents in part, at beginning of shift, resident was noted in the bed sleeping. At approximately 7:30 AM, the resident got the writer's attention. She was requesting to go to the hospital. Writer asked why but resident refused to give any further information. Writer assessed the resident. The resident was not in any distress at this time. The physician was notified with an order to send the resident to the hospital. On 2/5/25 at 10:40 AM, R5's progress note documents in part, at approximately 10:30 AM, writer was making rounds noted resident having seizures that lasted a second. 911 was called. 911 crew arrived; resident was picked up by 911 crew at approximately 10:48 AM. R5 was taken to the hospital for further evaluation. On 2/5/25 (no time), R5's ambulance run sheet documents in part, per staff patient was witnessed to have a convulsive seizure lasting approximately one minute while in bed. Staff report finding a needle and syringe in bed with patient and patient has history of opioid dependence. On 2/5/25 at 2:52 PM, R5's emergency room record documents R5 required urgent endotracheal intubation (inserting a tube into the windpipe) for airway protection. On 2/5/25, facility's incident report documents in part, resident requesting to go to hospital due to seizures. When cleaning the room, the nurses found two syringes, one empty, one used. The visitor log was checked; resident had visitor in lobby. Suspected visitor gave her the drugs. Resident was put on supervised pass. Outside Pass Privilege (Mental Health Client) care plan (initiated/created 1/17/25, revised 2/5/25) documents in part, (R5) does not appear capable of limited IOOP (Independent Out on Pass). The resident (R5) has history of substance abuse and exhibits drug-seeking behavior care plan (initiated/created 2/5/25). Goal: Reduce drug-seeking behavior and promote recovery-focused care. Interventions include but are not limited to staff will prevent access to unauthorized substances. Goals and interventions initiated/created 2/5/25. Substance abuse care plan (initiated/created 2/27/25, revised 3/3/25) documents R5 has a history of substance abuse and has overdosed in the past. R5 has a history of opioid use and is receiving methadone as medication assisted treatment to address her substance use. Goals include: R5 will meet with the facility psychotherapist to discuss emotions. Interventions include work with the resident to develop long term goals focused on maintaining sobriety, building healthy coping skills, and avoiding situations that may trigger relapse. Goals and interventions were initiated/created on 2/27/25, after complaint investigation initiated on 2/21/25. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3d.) Fourth, a form was created listing all residents with a history of substance abuse and will be reviewed weekly by the Social Services team and Leadership to ensure that all on this list are being compliant with substance abuse protocols. A list of residents with a history of substance abuse will be placed in each nursing station and updated weekly. (See Exhibit 4-Security Committee Form Exhibit 5- A Residents with History of Substance Abuse List). 3e.) The facility will conduct a QA Audit designed to ensure comprehensive and through investigation of any illicit drug distribution, promoting safety, accountability and transparency. These audits will be conducted by the Administrator and Assistant Administrators. This QA audit was initiated on 3/14/25 and will be conducted when there is any suspicion of illicit drug use or an allegation of illicit drug distribution. (See Exhibit 5-B QA Tool For Investigation of Illicit Drug Use or Distribution) 4.) Package Security Procedure: On 3/13/25 Administrator, Assistant Administrators, and IDT collaborated and began to look at protocol to prevent dangerous items from entering the facility. The purpose of this protocol is to prevent dangerous items from being delivered or dropped off to residents in the facility through the mail system or individuals. On packages arriving to the facility by U.S. Mail, Fed Ex, etc., the Receptionist/Security will check the package in at the Front Desk. After the package is received the Receptionist/Security places the item in a secured office adjacent to the Front Desk area where only the Front Desk, Security, and Leadership have access. Receptionist/Security staff will then inform Activities Staff/Representative that there is a resident package that has arrived and is being placed in the secured office area. Activity staff/representative will then pick up the package and deliver it to the resident where he/she will be asked to open it in front of them. (See Exhibit 6- Mail Log) Once the package has been determined to be safe and free of any contraband, the Activity staff/Representative will enter the package into Mail Log for tracking. If the package is not considered to be safe, Security personnel will be called to the location and will gather up the package where it will be placed in a secure location. For packages/items delivered by individuals as opposed to the mail system, the family member/other will be required to open the package in front of the Security Guard where it will be inspected for contraband. Once the package is cleared, the family member/other will receive the package back and can continue with their visit. 4a.) Security, Activities, and Front Office staff were in-serviced on being able to identify specific types of unauthorized items which includes illicit substances to optimally prevent illicit substances from entering the facility. In-servicing of Security, Activities, and Front Office Staff was completed by the Assistant Administrator. (See Exhibit 7A- Visitor Package Tracking Log and Exhibit 7B-In-Service on Package Security Procedure / Mail Log (Residents & Visitors)/IOOP Procedure) (Exhibit 7C-Prohibited Items List) (continued on next page)

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 03/25/2025
NAME OF PROVIDER OR SUPPLIER Chalet Living & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 7350 North Sheridan Road Chicago, IL 60626	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4b.) All residents were informed Activities staff/Designee of this new process on 3/14/25. (See Exhibit 8-Resident In-Service Sheet regarding Package Security Procedure) 4c.) This process will be posted at the Front Desk to make visitors aware of this process when they bring in packages for residents. (See Exhibit 9-Package Security Procedure Posting) 4d.) This process will be reviewed at the emergency Resident Council Meeting on 3/17/25 and monthly thereafter for 3 months (See Exhibit 10A-Resident Council Agenda for March 17, 2025, and Exhibit 10B - Resident Council Sign in sheet) 4e.) All new admissions will be informed of the Package Security Procedure upon Admission by Admissions Director/Designee. (See Exhibit 11-QA Tool verifying Admissions Director/Designee reviewed and presented new admission with Package Security Procedure) 4f.) The facility conducted a QA Audit 2x/weekly x 12 weeks to ensure new admissions were aware of the Package Security Procedure and the process is being implemented and followed as recommended. This audit will be conducted by the Assistant Administrator or designee. This QA started on 3/14/25. 5.) Independent/Community Out on Pass Protocol Relating to All Residents and A focus on Residents with A History of Substance Abuse. The purpose of this protocol is to prevent all residents, including those with a history of substance abuse, and visitors from bringing illegal substances into the facility upon returning from out on pass. 5a.) On 3/19/25 Administrator, Assistant Administrators, and IDT collaborated and began to review protocol to prevent all residents, including those with a history of substance abuse, and visitors from bringing illegal substances into the facility after returning from out on pass. 5b.) A sign will be placed in a predominant location in the Front Lobby Area notifying all residents, while out on pass, and visitors entering the facility not to bring illicit substances into the facility and if they are suspected/caught they will be subject to police intervention. (See Exhibit AB Front Desk Poster) 5c.) In order to remind All Residents, including those with a History of Substance Abuse, not to bring illicit substances into the facility when going out on pass, a statement will be boldly printed on the bottom of the resident out on pass log stating that if he/she brings illicit substances back into the facility, they will be subject to restricted out on pass and or immediate police intervention. The Posting will also be in immediate view of the Reception Desk to further remind a resident of the repercussions of bringing illicit substances into the facility. If a resident is caught in the facility utilizing or distributing illicit drugs on more than one occasion, he or she will be reported to the police as well as Involuntarily discharged to promote the safety of both residents, visitors, and staff. (See Exhibit AC Resident Out on Pass Log) 5d.) A destination section is located on the Resident Out on Pass Log in order for the resident to declare each time he/she goes Out on Pass. It will be the responsibility of Security/Front Desk staff to ensure that this section is consistently and accurately filled out and in the Destination Section. (See Exhibit AC Resident Out on Pass Log) (continued on next page)

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	03/25/2025

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5e.) To prevent residents and visitors, who do not have a documented history of substance use from bringing illicit substances into the facility, the Security Team/Front Desk Staff will strongly request any visitor or resident en [TRUNCATED]