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	01/09/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record reviews, the facility failed to follow their policy and provide an adequate number of staff to meet resident needs based on their facility assessment. This has the potential to affect all 194 residents residing in the facility. Findings include: On 01/07/2026 at 1:54PM, V15 (Scheduling Coordinator) states she has been the scheduling coordinator for two years and she makes the schedule for the CNAs only. V15 states V4 (Director of Nursing/DON) makes the schedule for the nurses. V15 states for the day and evening shift, the facility should have 5 CNAs for the 4th floor, 5 CNAs for the 3rd floor, and 4 CNAs for the 2nd floor. V15 states for the night shift, the facility should have 3 CNAs for all floors of the facility. V15 states the facility does not use agency staffing to supplement staffing in the facility. V15 states she has not received any concerns related to lack of nursing staff. V15 states she staff according to a budget provided to her by the facility. V15 states she was told that she could staff 15 CNAs for the morning and evenings and 9 CNAs for the night shift. V15 state she is unaware of the staffing budget and is unaware of the minimum staffing requirements for the facility. On 01/07/2026 at 2:08PM V4 (DON) states he is responsible for staffing for the nurses in the facility. V4 states the facility does not use agency staffing to supplement facility staffing. V4 states he always ensures to staff 2 nurses on each floor for each shift. V4 states he staffs for a total of 18 per day in the facility. V4 states he always staff 18 nurses a day and never fall below the minimum of 18 nurses per day to work in the facility. V4 states the total number of CNAs that the facility staffs on a daily basis are 37 per day. V4 states he is not aware of low nursing staffing on the weekends. V4 states he is not responsible for submitting the facility's payroll-based journal/PBJ information for employee staffing. Facility nursing staff time punch reports reviewed for nurses and CNAs from 07/01/2025 to 09/30/2025 for weekend shifts. The nursing staff time reports documents that out of the 26 weekend days reviewed, there were 26 days that did not meet the minimum requirements of 18 nurses and 37 CNAs per V15 (Scheduling Coordinator) and facility assessment. CMS (Centers for Medicare & Medicaid Services) PBJ (Payroll Based Journal) Report for facility's Fiscal Quarter 4 2025 (July 1 - September 30) documents in part that the facility triggered for excessively low weekend staffing.Facility assessment dated [DATE] documents in part a staffing of two nurses per shift per each floor, five CNAs (Certified Nurse Aides) for morning shift, five CNAs during evening shift, and three CNAs during night shift for each floor of the facility. The facility has a total of three floors and three shifts per day, so this equals approximately 39 CNAs per day. The facility assessment also documented that they staff for 13 CNAs per day, which was contradictory to what the other portion of the facility assessment stated regarding approximately 39 CNAs to be staffed daily. The facility assessment regarding the 13 CNAs per day also contradicts what the staffing scheduler and DON said the total CNA staffing should be (Approximately 37 CNAs daily).Facility policy dated 07/03/2025 titled Staffing documents in part, It is the facility's policy to provide adequate staff to meet the needs of the residents which is the requirement under the federal regulations. The facility will provide 3.8 hours of nursing and personal care each day for a resident needing skilled care and 2.5 hours of nursing and personal care each day for a resident needing intermediate care.

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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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to follow their Storage of Medications policy and store medications in locked compartments for 1 of 6 medication carts. This has the potential to affect all 36 residents receiving medication from team one medication cart. Findings IncludeOn 1/6/26 at 9:26 AM observed V14 (Licensed Practical Nurse/LPN) prepared R34's medications and walked away from medication cart unlocked and out of sight. On 1/6/26 at 9:35 AM, observed V14 prepared R131's medications and walked away from medication cart unlocked and out of sight. On 1/6/26 at 9:45 AM observed V14 prepared R122's medications and walked away from medication cart unlocked and out of sight. On 1/6/26 at 9:50AM observed V14 prepared R144's medications and walked away from medication cart unlocked and out of sight. On 1/6/26 at 10:10 AM observed V14 prepared R107's medications and walked away from medication cart unlocked, left medication on top of the cart and out of sight. On 1/6/26 at 10:22 AM V14 (LPN) stated, I forgot to lock the medication cart, I was not focused. Whenever, I walk away from the medication cart there should not be any medication on top of the cart, another resident or unlicensed person could have taken the medication or went into the medication cart. On 1/6/26 at 11:15 AM, V5 (Assistant Director of Nursing) stated, The medication cart should aways stay locked when the nurse is not utilizing the cart. If the cart is not locked and the licensed nurse is not present another resident or any unlicensed personnel could take medication that could potentially harm them. Policy documented in part: Controlled Substance Prescriptions: dated 8/2020.Security and Record KeepingControlled substance, medications are stored at the facility under double lock or as required by state regulations, separate from all other medications and counted at each change of custody. The medication nurse on duty maintains possession of a key for controlled medications. Medication Pass dated 7/2/25.After medication is administered to each resident, sign the medication administration records that it was given. Storage of Medications Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes containing drugs and biologicals shall be locked when not in use and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review the facility failed to follow portion sizes listed on spreadsheets. These failures have the potential to affect the five residents receiving pureed diets and 163 residents receiving regular consistency diets of food prepared in the facility's kitchen. Findings Include:On 01/07/26 at 10:25 AM, during pureed food preparation V27 (Cook) stated she will be preparing pureed chicken, pureed vegetables, and pureed rice today for lunch. V27 stated she will be making eight portions of pureed food. Observed metal container with individual pieces of cooked chicken breast inside. V27 used tongs to put eight pieces of the chicken breast into the commercial blender and then added two cups of measured chicken broth and turned on the blender to reach desired pureed consistency. Surveyor noted many leftover pieces of cooked chicken inside the metal container.On 01/07/26 at 10:29 AM, observed V27 transfer the pureed chicken to a metal container, cover with foil and put into the oven to reheat before the lunch tray line started.On 01/07/26 at 10:34 AM, surveyor asked V27 to weigh out one of the pieces of cooked chicken breast used to make the pureed chicken. V27 retrieved a digital scale and placed a piece of plastic wrap over the digital scale and then tarred the scale before she added one piece of the cooked chicken breast. Surveyor observed the digital scale to read 2.5-ounces. V27 said, I need to make more pureed chicken because the portion should be 3 ounces. V27 indicated that she had not weighed out the cooked chicken breast prior to the surveyor's request.On 01/07/26 at 10:38 AM, observed V27 add six pieces of cooked chicken breast to the commercial blender, add one cup of chicken broth and turned on the machine to puree chicken to appropriate consistency.On 01/07/26 at 10:45 AM, V26 (Food Service Director) stated since V27 made the extra pureed chicken the residents will get the correct portion of 3-ounces of pureed chicken. V26 noted that if the surveyor had not requested for the chicken to be weighed the residents on pureed diet would have received 2.5 ounces of pureed chicken instead of 3 ounces of chicken.On 01/07/26 at 11:20 AM, the lunch tray line started. Observed V27 reading the meal tickets and plating food. For residents on regular diet consistency V27 was giving them one piece of chicken. Surveyor noted that the pieces of chicken being put on the resident's plate appeared small.On 01/07/26 at 11:29 AM, as the tray line was running observed V27 select one chicken thigh using tongs and placed it on a plate with rice and vegetables for a resident. Right before the plate was going to put into the food cart the surveyor asked V27 to remove the chicken thigh from the plate and weigh that piece of chicken. V27 placed the chicken thigh on a separate plate and gave it to the surveyor. The surveyor then asked for someone to weight the chicken thigh.On 01/07/26 at 11:32 AM, V26 placed a piece of plastic wrap on the digital scale, tarred the scale and then added the chicken thigh given to the surveyor by V27. V26 stated the reading on the scale was 2.4 ounces (including the bones and skin). Surveyor asked V26 to remove the bones and skin from the piece of chicken and reweigh the edible pieces of the chicken. V26 did as instructed, retarred the digital scale and placed the edible pieces of chicken back on the scale (no bones, no skin). Surveyor observed the scale to read 1.4 ounces. V26 stated the reading on the scale was 1.4 ounces.On 01/07/26 at 11:38 AM, V26 checked the Diet Guide Sheet and stated the portion of chicken served should be 3 ounces. V26 stated they will need to give the residents extra portions of chicken for the residents to get the 3 ounces of chicken required.On 01/07/25 at 4:00 PM, V25 (Registered Dietitian) stated the Diet Guide Sheets should be followed by the kitchen. V25 stated this is important so that the residents receive the correct items in the correct consistency based on their diet order and that the portions are followed so that they can receive the correct amount of nutrition including calories, protein, vitamins/minerals. V25 stated for the lunch served today on 01/07/26 the regular diet orders should receive 3 ounces of chicken, and the pureed diets should receive #8 scoop (4 ounces) of pureed chicken because that is what is listed on the Diet Guide Sheets. V25 stated the pureed portion is more than the regular portion (4 ounces versus 3 ounces) because of the added liquid needing to puree the item to the correct (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	consistency. V25 stated she was made aware of the issue at lunch with the chicken used to prepare the pureed chicken being 2.5 ounces instead of 3 ounces and the chicken for the regular diets being less than the 3-ounces. V25 acknowledged that if the surveyor had not asked for the chicken to be weighed the residents may not have received the correct portion and therefore not gotten enough nutritional value out of what they received for that meal. V25 stated the 3 ounces chicken should be edible protein (excluding bones and skins). V25 stated if the edible part of the chicken served to regular diets was 1.4 ounces on the scale than that was wrong because it should have been 3 ounces. V25 stated some of the residents complain about the portions being small, it depends on the resident and their situation. V25 stated milk is provided upon request, otherwise it is not automatically added to trays at meals.Facility provided Diet Tally Report dated 01/07/26 which documents five residents on pureed textured diet and 163 residents on a regular textured diet. Facility provided document titled Diet Guide Sheet for Wednesday (Day 18) which documents in part for lunch pureed diets to receive pureed oven fried chicken #8 scoop and regular diets to receive 3 ounces oven fried chicken.Facility provided kitchen policy titled, Menus dated 02/19/25 which documents in part, it is the center policy that menus are planned in advance, and to meet the nutritional needs of the residents/patients, will be developed utilizing an established national guideline and menus are served as written, unless changed in response to preference, unavailability of an item or a special meal.Facility provided document titled [NAME] Job Profile undated which documents in part, job responsibilities include but not limited to prepare and cook flavorful, yet visually appealing meals following standardized recipes, nutritional guidelines, and resident dietary needs.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review the facility failed to ensure an allegation of abuse was reported to the state surveying agency, within two hours of notification of the abuse allegation for 1 (R44) resident reviewed for abuse in a sample of 35.Findings Include:R44 has diagnosis not limited to Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation, Abnormalities of Gait and Mobility, Anxiety Disorders, Depressive Episodes, Other Psychoactive Substance Abuse, Essential (Primary) Hypertension and Other Recurrent Depressive Disorders. R44's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 12 indicating moderate impairment. R44's Care Plan document in part: Focus: History of Suspected Abuse/Neglect The resident's comprehensive assessment reveals a history of suspected abuse and/or neglect or factors that may increase his/her susceptibility to abuse/neglect. A history and/or personality that draws him/her into unhealthy, even abusive, relationships., Behavior that might be characterized as provoking, antagonizing, disrespectful, angry, insensitive, and/or annoying, Behavioral symptoms, Difficulty in adjustment and generalized mood distress.R44's letter addressed to V1 (Administrator) or V2 (Executive Director) dated Sunday (01/04/26) 05:10 PM document in part: the certified nurse assistant who delivers food to my side was hostile to my roommate regarding her asking to be changed. I asked the certified nurse assistant not to yell at R37 like that and how she would feel in R37's shoes. V17 (Certified Nurse Assistant) told me to shut up and mind my own business. I told her to get out of my way I was going to the front desk. V17 blocked me and my cart, refusing to move and continued ranting. I said get out of our room, to which she said if I tried to get by her, she'd throw me out the window. I got by V17 when she moved to the door and told the nurse. V17 pushed pass me bumping me. I got in the elevator and came to send you this letter. I told her she'll get fired for threatening a patient! Please take action this shouldn't happen. I'm a nervous wreck! I'm literally shaking.On 01/06/26 at 12:29 PM R44 stated Two days ago (01/04/25), a certified nurse assistant (V17 Certified Nurse Assistant) that work 3 pm came into my room at around 5 pm to give the dinner tray. The certified nurse assistant was African American. She was supposed to come change R37 but said that she will come back in a couple hours. I told her (V17) would she like to lay in her urine. She (V17) said get out my face, f**k you. She (V17) would not let me pass to leave the room and threatened to throw me out the window. She (V17) scared the hell out of me, and I was shaking like a leaf. I tried to get her name, but no one would tell me her name. Abuse does not need to be on the job at least show compassion because I have heart problems. I went to the nurse station and told the nurse. There was two other people at the nurse station. I then got on the elevator, went down stair to report it. I was explaining to the receptionist what happened, and she was so understanding. The receptionist gave me a pen/paper, I wrote a letter, and the receptionist put it in the administrator mailbox. I told V2 (Executive Director) and V6 (Social Worker).On 01/06/26 at 01:44 PM V6 (Social Worker) stated R44 complained to me that a staff member was very abusive, and I reported it to V2 (Executive Director).On 01/06/26 at 02:21 PM V2 (Executive Director) stated I was upstairs doing other things and a whole lot of stuff was going on yesterday when R44 interrupted me. I took time to speak to R44 and she had a generalized story that a certified nurse assistant (V17) came in to take care of her roommate when her (R44) and the certified nurse assistant (V17) got into a confrontation. R44 said the certified nurse assistant (V17) was in the room, dropped off food and R37 had to be changed. R44 described the certified nurse assistant as wearing a wig and is heavyset. I checked the schedule, and the certified nurse assistant was here this morning. The certified nurse assistant (V17) said I have to finish passing out food and R44 started yelling at her. I did the reportable as soon as V6 (Social Worker) told me about it today. R44 is care planned because she gets involved in other resident care. R44 said the certified nurse assistant threatened her. I got the letter that R44 wrote this morning, it was in my mailbox. I would consider that as abuse and I probably should have reported it yesterday. I thought R44 was having (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	psychosis based off her care plan.On 01/06/26 at 03:23 PM V2 (Executive Director) stated I don't take abuse lightly and should have reported the abuse allegation yesterday (01/05/26).01/07/26 at 10:23 AM V6 (Social Worker) stated R44 came to my office to talk to me yesterday (01/06/26) morning. R44 said one certified nurse assistant had talked to her in an incorrect way. I immediately let V2 (Executive Director) know, and he handled it from there. R44 did not tell me the exact date that it happened. R44 said she was not comfortable the way the certified nurse assistant talked to her.On 01/07/26 at 11:29 AM per telephone interview V7 (Receptionist) stated On 01/04/26 I worked a double. R44 came downstairs in the evening. R44 complained and asked when the administrator is going to be here. I told R44 I can I get them a note and R44 asked for pen and paper to leave the note. R44 complained something about the nursing staff. R44 said someone threatened to push her out the window then she went and sat down to write the letter. I put the letter in the administrator mailbox. Surveyor asked V7 would that have been considered an allegation of abuse. V7 responded that is like a threat. The way R44 expressed it, if it true and if she felt threatened, I guess that is abuse. If there is an allegation or I witness abuse I would contact the administrator. I did not follow protocol. I probably dropped the ball because I felt it was more of a complaint.On 01/07/26 at 02:20 PM Per telephone interview V17 (Certified Nurse Assistant) stated I worked on the second floor 01/04/26 on the 3-11 PM shift. I did patient care and passed meal trays. I was passing trays going toward R44's room and saw the call light on. I dropped off the meal tray and said R44 that's your meal tray. It was 05:30 PM and I asked R37 if she wanted me to change her (R37) but she wanted to eat and said come back at six. R44 said that is a breach of the contract, you don't have to time R37. I asked R44 can you mind your business. R44 got her walker and was hitting on me on my leg. I asked R44 what have I done to her. R44 said I am going to fire you. I never experienced this character from R44, and I never said I was going to throw her out the window. I was surprised at how R44 was pushing me with her walker. R44 was passing the nurse station and went downstairs. R44 reported me that I said that I was going to throw her out the window. I did not do anything or say anything to R44. When R44 was passing the nurse station she told me to look for another job.On 01/09/26 08:01 AM per telephone interview V20 (Certified Nurse Assistant) stated On Sunday 01/04/26 R44 said to V17 (Certified Nurse Assistant) that she was going to report and fire V17 when she came to the elevator. V17 said that she did not do anything to R44.Reportable dated 01/06/26 12:10 PM document in part: Subject R44 and staff. Abuse Report Initial Form: Allegation Type: Verbal/Mental. Information about when the facility became aware of the incident: 01/06/26 10:30 AM. Name of staff who 1st became aware of the incident: V1 (Administrator). Alleged Victim: R44. Alleged perpetrator: Unknown. Allegation Details: On 01/06/26 R44 spoke to Administrator. A few nights ago, a C.N.A. (Certified Nurse Assistant) on the 2nd shift was being rude to me and telling me not to get involved I other patients care.In-service Attendance Training dated 01/06/26 document in part: Topic: Timely reporting of Abuse, Identifying Abuse, Abuse Policy, (7) Key Components of Abuse, Abuse Types, Review of Abuse Scenarios, Review of Specific Reportable Prioritizing and Investigating.In-service Attendance Training dated 01/06/26 document in part: Topic: Abuse and Neglect Policy and Procedure, Timely reporting, Identifying Abuse and (7) Key Components of Abuse and Neglect Prevention.In-service Attendance Training dated 01/07/26 document in part: Topic: Abuse and Neglect and Policy and Procedure, Timely reporting, Identifying Abuse, (7) Key Components of Abuse, Neglect and Prevention.Policy:Titled Abuse and Neglect revised 06/26/25 document 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. The facility follows the federal guidelines dedicated to prevention abuse and timely and thorough investigations of allegations. If abuse/neglect is suspected the facility will: 1: Take immediate steps to assure the protection of the resident(s). 2. Notify the appropriate/designated organization/authority (IDPH) that an investigation is being initiated immediately following interventions for the resident's safety. VI. Protection: Have procedures to: Employee(s) accused must (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be suspended pending investigation. V11. Reporting/Response. All allegations and/or suspicions 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 allegations of abuse will be reported to IDPH immediately not exceeding 2 hours after the initial allegation is received.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review the facility failed to initiate an investigate immediately of an allegation of Abuse for 1 (R44) resident reviewed for abuse in a sample of 35. Findings Include:R44 has diagnosis not limited to Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation, Abnormalities of Gait and Mobility, Anxiety Disorders, Depressive Episodes, Other Psychoactive Substance Abuse, Essential (Primary) Hypertension and Other Recurrent Depressive Disorders. R44's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 12 indicating moderate impairment. R44's Care Plan document in part: Focus: History of Suspected Abuse/Neglect The resident's comprehensive assessment reveals a history of suspected abuse and/or neglect or factors that may increase his/her susceptibility to abuse/neglect. A history and/or personality that draws him/her into unhealthy, even abusive, relationships., Behavior that might be characterized as provoking, antagonizing, disrespectful, angry, insensitive, and/or annoying, Behavioral symptoms, Difficulty in adjustment and generalized mood distress. R44's letter addressed to V1 (Administrator) or V2 (Executive Director) dated Sunday (01/04/26) 05:10 PM document in part: the certified nurse assistant who delivers food to my side was hostile to my roommate regarding her asking to be changed. I asked the certified nurse assistant not to yell at R37 like that and how she would feel in R37's shoes. V17 (Certified Nurse Assistant) told me to shut up and mind my own business. I told her to get out of my way I was going to the front desk. V17 blocked me and my cart, refusing to move and continued ranting. I said get out of our room, to which she said if I tried to get by her, she'd throw me out the window. I got by V17 when she moved to the door and told the nurse. V17 pushed pass me bumping me. I got in the elevator and came to send you this letter. I told her she'll get fired for threatening a patient! Please take action this shouldn't happen. I'm a nervous wreck! I'm literally shaking. On 01/06/26 at 12:29 PM R44 stated two days ago (01/04/25), a certified nurse assistant (V17 Certified Nurse Assistant) that work 3 pm came into my room at around 5 pm to give the dinner tray. The certified nurse assistant was African American. She was supposed to come change R37 but said that she will come back in a couple hours. I told her (V17) would she like to lay in her urine. She (V17) said get out my face, f**k you. She (V17) would not let me pass to leave the room and threatened to throw me out the window. She (V17) scared the hell out of me, and I was shaking like a leaf. I tried to get her name, but no one would tell me her name. Abuse does not need to be on the job at least show compassion because I have heart problems. I went to the nurse station and told the nurse. There was two other people at the nurse station. I then got on the elevator, went down stair to report it. I was explaining to the receptionist what happened, and she was so understanding. The receptionist gave me a pen/paper, I wrote a letter, and the receptionist put it in the administrator mailbox. I told V2 (Executive Director) and V6 (Social Worker). On 01/06/26 at 01:44 PM V6 (Social Worker) stated R44 complained to me that a staff member was very abusive, and I reported it to V2 (Executive Director). On 01/06/26 at 02:21 PM V2 (Executive Director) stated I was upstairs doing other things and a whole lot of stuff was going on yesterday when R44 interrupted me. I took time to speak to R44 and she had a generalized story that a certified nurse assistant (V17) came in to take care of her roommate when her (R44) and the certified nurse assistant (V17) got into a confrontation. R44 said the certified nurse assistant (V17) was in the room, dropped off food and R37 had to be changed. R44 described the certified nurse assistant as wearing a wig and is heavyset. I checked the schedule, and the certified nurse assistant was here this morning. The certified nurse assistant (V17) said I have to finish passing out food and R44 started yelling at her. I did the reportable as soon as V6 (Social Worker) told me about it today. R44 is care planned because she gets involved in other resident care. R44 said the certified nurse assistant threatened her. I got the letter that R44 wrote this morning, it was in my mailbox. I would consider that as abuse and I probably should have reported it yesterday. I thought R44 was having psychosis based off her care plan. On 01/06/26 at 03:23 PM V2 (Executive Director) stated I don't take abuse lightly and should have reported the abuse allegation (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	yesterday (01/05/26). 01/07/26 at 10:23 AM V6 (Social Worker) stated R44 came to my office to talk to me yesterday (01/06/26) morning. R44 said one certified nurse assistant had talked to her in an incorrect way. I immediately let V2 (Executive Director) know, and he handled it from there. R44 did not tell me the exact date that it happened. R44 said she was not comfortable the way the certified nurse assistant talked to her. On 01/07/26 at 11:29 AM per telephone interview V7 (Receptionist) stated On 01/04/26 I worked a double. R44 came downstairs in the evening. R44 complained and asked when the administrator is going to be here. I told R44 I can I get them a note and R44 asked for pen and paper to leave the note. R44 complained something about the nursing staff. R44 said someone threatened to push her out the window then she went and sat down to write the letter. I put the letter in the administrator mailbox. Surveyor asked V7 would that have been considered an allegation of abuse. V7 responded that is like a threat. The way R44 expressed it, if it true and if she felt threatened, I guess that is abuse. If there is an allegation or I witness abuse I would contact the administrator. I did not follow protocol. I probably dropped the ball because I felt it was more of a complaint. On 01/07/26 at 02:20 PM Per telephone interview V17 (Certified Nurse Assistant) stated I worked on the second floor 01/04/26 on the 3-11 PM shift. I did patient care and passed meal trays. I was passing trays going toward R44's room and saw the call light on. I dropped off the meal tray and said R44 that's your meal tray. It was 05:30 PM and I asked R37 if she wanted me to change her (R37) but she wanted to eat and said come back at six. R44 said that is a breach of the contract, you don't have to time R37. I asked R44 can you mind your business. R44 got her walker and was hitting on me on my leg. I asked R44 what have I done to her. R44 said I am going to fire you. I never experienced this character from R44, and I never said I was going to throw her out the window. I was surprised at how R44 was pushing me with her walker. R44 was passing the nurse station and went downstairs. R44 reported me that I said that I was going to throw her out the window. I did not do anything or say anything to R44. When R44 was passing the nurse station she told me to look for another job. On 01/09/26 08:01 AM per telephone interview V20 (Certified Nurse Assistant) stated On Sunday 01/04/26 R44 said to V17 (Certified Nurse Assistant) that she was going to report and fire V17 when she came to the elevator. V17 said that she did not do anything to R44. Reportable dated 01/06/26 12:10 PM document in part: Subject R44 and staff. Abuse Report Initial Form: Allegation Type: Verbal/Mental. Information about when the facility became aware of the incident: 01/06/26 10:30 AM. Name of staff who 1st became aware of the incident: V1 (Administrator). Alleged Victim: R44. Alleged perpetrator: Unknown. Allegation Details: On 01/06/26 R44 spoke to Administrator. A few nights ago, a C.N.A. (Certified Nurse Assistant) on the 2nd shift was being rude to me and telling me not to get involved I other patients care. The allegation of Abuse happened on 01/04/26 and was reported to V7 (Receptionist) by R44. V7 failed to report the allegation of abuse to the abuse coordinator. The Abuse Coordinator is V1 (Administrator) however V2 (Executive Director) spoke with R44 on 01/05/26 concerning the abuse allegation and failed to submit an Initial Reportable or start an investigation until V6 (Social Worker) reported the alleged abuse to him (V2) on 01/06/26. V17 (Certified Nurse Assistant) did not work on 01/05/26 but was assigned to the unit in which R44 resides on 01/06/26. On 01/06/26 V2 identified the perpetrator as V17 after which time V17 was suspended and sent home pending the outcome of the investigation. The facility started to in-service the staff concerning abuse/abuse reporting/abuse investigating on 01/06/26. In-service Attendance Training dated 01/06/26 document in part: Topic: Timely reporting of Abuse, Identifying Abuse, Abuse Policy, (7) Key Components of Abuse, Abuse Types, Review of Abuse Scenarios, Review of Specific Reportable Prioritizing and Investigating. In-service Attendance Training dated 01/06/26 document in part: Topic: Abuse and Neglect Policy and Procedure, Timely reporting, Identifying Abuse and (7) Key Components of Abuse and Neglect Prevention. In-service Attendance Training dated 01/07/26 document in part: Topic: Abuse and Neglect and Policy and Procedure, Timely reporting, Identifying Abuse, (7) Key Components of Abuse, Neglect and Prevention.Policy:Titled Abuse and Neglect revised 06/26/25 document in part: it is the policy of the facility to provide professional care and services in an (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment. The facility follows the federal guidelines dedicated to prevention abuse and timely and thorough investigations of allegations. If abuse/neglect is suspected the facility will: 1: Take immediate steps to assure the protection of the resident(s). 2. Notify the appropriate/designated organization/authority (IDPH) that an investigation is being initiated immediately following interventions for the resident's safety. 3. Conduct a careful and deliberate investigation centering on facts, observations and statements from the alleged victim and witnesses. VI. Protection: Have procedures to: Employee(s) accused must be suspended pending investigation. V11. If the Administrator is not present, the report must be made to the Administrator's designee. All allegations of abuse will be reported to IDPH immediately not exceeding 2 hours after the initial allegation is received.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interviews and record reviews, the facility failed to refer a resident (R18) who was later identified with a mental disorder to the appropriate state-designated authority for a Level II PASARR (Preadmission Screening and Resident Review) evaluation and determination for one out of a total sample of 35 resident. Findings include: R18's 7/17/2024 Notice of PASRR (Preadmission Screening and Resident Review) Level I Screen Outcome documents in part no level II required due to R18 not having a severe mental illness, intellectual disability or related condition. There was no mental health diagnosis known or suspected and no mental health medications during the assessment. R18's admission Record documents in part an initial/original admit date of 7/25/2024. It documents in part a diagnosis of schizoaffective disorder (onset 1/17/2025). V33's (Psychiatrist) 8/08/2024 12:57 PM progress note for R18 documents in part: Diagnosis: Schizoaffective [diagnosis], depressed type. Past Psychiatric History: Schizoaffective. V33 wrote historical medication to include lithium. V33 wrote to add Seroquel (antipsychotic) 50 milligrams at night to R18's medications. On 1/07/2026 at 1:18 PM, V8 (Nurse Consultant) stated R18 did not have the diagnosis of schizoaffective disorder during admission. V8 stated R18's hospital and referral paperwork also did not contain the diagnosis for R18. Requested R18's Level II PASARR. V8 stated facility did not resubmit for a Level II PASARR; therefore, R18 did not have one. On 1/07/2026 at 3:13 PM, V11 (Admissions Director) stated R18's initial PASRR Level I was done at the hospital prior to admission. V11 stated if there was a new diagnosis of schizoaffective disorder or if the diagnosis was missed during the first assessment, R18 should have gotten a new PASARR. Facility's Pre-admission Screening and Resident Review (PASARR) Policy (adopted 7/16/2025) documents in part: If the referring hospital fails to submit any information showing the psychiatric disorders/diagnoses, substance use history, and mental health medications in the referral information to the facility and the facility suspects a MD [mental disability] or ID [intellectual disability], the facility will notify the appropriate state-designated mental health or intellectual disability authority by requesting a PASSAR screening via AssessmentPro (Apro). The facility will notify the appropriate state-designated mental health or intellectual disability authority by requesting a PASSAR screening via AssessmentPro (Apro), if a new psychiatric diagnosis under MD or ID is added by a physician.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to refer a resident to the appropriate state-designated authority for a new Level II PASARR evaluation and determination with known mental illness for two (R11, R14) residents reviewed for Pre-admission Screening and Record Review (PASARR) in a total sample of 35 residents reviewed. Findings include: R11's Facesheet documents that R11 was admitted to the facility on [DATE] with diagnoses not limited to bipolar disorder, current episode depressed, severe, with psychotic features, post-traumatic stress disorder, chronic R11's PASARR screening dated 06/09/2024 documents that R11 does not require a level II PASARR due to no SMI (severe mental illness)/ID (intellectual disability)/ RC (related concerns). R14's face sheet documents that R14 was admitted to the facility on [DATE] with admission diagnoses not limited to Schizoaffective Disorder, Bipolar Type, Other Recurrent Depressive Disorders, Mild Neurocognitive Disorder Due to Known Physiological Condition without Behavioral Disturbance. R14's Order Summary Report dated 01/07/26 indicates in part that R14 is receiving Aripiprazole for psychosis 10 mg tablet one time a day. R14's Care Plan Report documents in part R14 has a diagnosis and history of severe mental illness and requires psychotropic medication. R14's PASARR screening dated 02/13/2023 documents in part, you do not have a mental health condition requiring evaluation through the PASRR process. If a change occurs suggesting that you do have a mental health, intellectual or developmental disability, then further evaluation through the PASRR process will be needed. You do not require further evaluation through the PASRR process. Your depression and confusion are noted. However, you have not been diagnosed with a serious mental illness. It is noted that you do not currently take any medication for your mental health. The current focus of your care is treatment of your medical conditions and planning for your care after you leave the hospital. The only DSM diagnoses listed on R14's Illinois PASRR Summary of Findings is Depression. No other DSM diagnoses included. On 01/07/2026 at 3:07PM, V11 (Admissions Director) states he has been working at the facility for 2.5 years and is responsible for performing the PASARR screenings for the residents. V11 states he checks the screening agency's website every day to check to see if there are any screenings that requires his attention. V11 states he is responsible for entering the resident's information, such as medications and diagnoses, into the screening agency's website. V11 states usually, the hospital completes a resident's PASARR prior to the facility admitting the resident to the facility. V11 states he is unsure of who is responsible for ensuring that resident's PASARR information is accurate prior to admitting the resident to the facility. V11 states a PASARR Level II is needed for a resident if the resident has a severe mental illness/SMI diagnosis. V11 states the determination for a Level II PASARR screening is based off of the results of the Level I PASARR screening. V11 states once he enters the resident's information, the screening agency will alert him if a resident requires a Level II PASARR screening. V11 states if information is entered into the resident's Level I PASARR screening incorrectly, then this can result in the PASSAR screening results being incorrect, which requires a (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	new screening to be completed. V11 states R11's current PASARR screening is inaccurate and requires a new PASARR screening to be completed due to R11's severe mental health diagnosis. Facility policy dated 07/16/2025 titled Preadmission Screening and Resident Review (PASARR) Policy documents in part, A PASARR level II is required to be done prior to admission if the PASARR Level I is positive for MD/mental disorder or ID/intellectual disability. PASRR Level I screen is to be completed before the individual is admitted to the facility. If it is not completed by the sending institution, it should be completed upon admission, or as soon as practicable thereafter.

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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. Based on observation, interview, and record review, the facility failed to follow facility smoking protocol to ensure that smoking materials are not kept by the resident in their room. This failure has the potential to affect 1 (R109) resident reviewed for smoking in a total sample of 35.Findings include:On 01/06/2026 at 11:28 AM, observed R109 lying on his bed in his room. R109 said, I smoke cigars. R109 stated he does not keep a lighter in his room and that someone outside lights his cigars for him. R109 stated that he keeps his cigars in his coat pocket. On 01/06/2026 at 11:30 PM, observed R109 walk to his closet and remove his coat. R109 then reached into his coat pocket and pulled out a box filled with brown cigarettes/cigars. R109 then reached back into his coat pocket and pulled out an additional 8-10 brown cigarettes/cigars. On 01/07/26 at 1:45 PM, V22 (Activity Aide) stated cigarettes/cigars are stored at the front desk and the residents are only allowed to have smoking materials on them when they are out at smoke break. V22 stated they are not allowed to take them (smoking materials) back on the nursing unit, everything is returned to the front desk. V22 stated even if a resident is allowed to smoke independently, they must still return their lighter and cigarettes/cigars to the front desk when they come back into the building.On 01/07/26 at 1:52 PM, V9 (Receptionist) stated there are four smoke breaks per day and he is involved in the 9AM and 1PM smoke breaks. V9 stated residents who have their own cigarettes store them in individual boxes kept behind the receptionist desk. V9 stated if a resident does not have their own cigarette, then he will give them a house stocked cigarette. V9 stated after the residents are done smoking, they come back to the receptionist desk and drop off their smoking material for storage. V9 stated none of the residents are allowed to have cigarettes/cigars and/or a lighter on their person due to safety reasons.On 01/07/26 at 2:11 PM, V23 (Social Worker) stated when a resident gets admitted the social service department assesses if the resident smokes or not. V23 stated through the smoking assessment it is determined if the resident can smoke independently or require supervised smoking breaks. V23 stated smoking on the patio is supervised because a staff is always monitoring those smoke breaks. V23 stated the facility does not allow lighters, cigarettes/cigars or e-cigarettes in the resident rooms and all smoking materials are kept at the front desk for safety concerns. V23 stated residents are not allowed to keep any smoking materials in their room. V23 stated R109 is complaint with the smoking rules, and she has not been made aware of any non-compliance issues with R109.On 01/07/26 at 2:29 PM, V23 went into R109's room and found inside R109's coat pocket a box of cigarettes/cigars, three additional unused cigarettes/cigars and six used cigarettes/cigars of various lengths. V23 stated R109 should not have these cigarettes/cigars in his room for safety reasons/concerns.R109's diagnosis included but not limited to Metabolic Encephalopathy, Bipolar Disorder, Unspecified Dementia, Cocaine Abuse, Schizophrenia, Mild Cognitive Impairment of Uncertain or Unknown Etiology, Auditory Hallucinations, Tobacco Use, Alcohol Use, Altered Mental Status.R109's MDS (Minimum Data Set) dated 10/22/25 indicates severely impaired cognition with BIMS (Brief Interview for Mental Status) 03 out of 15.R109's care plan report includes smoking care plan which documents (R109) is a smoker and expresses the desire to smoke at this facility. Interventions include but not limited to explain the consequences of smoking, this includes removal of all smoking materials and only being allowed to smoke when supervised.Smoking Behavior Agreement dated 10/17/25 signed by R109 indicating the resident agrees to the smoking policy. R109's Smoking Program Evaluation dated 10/17/25 which documented Resident is considered a safe smoker and may use/access smoking materials consistent with facility policy. Staff is not required to remain in attendance while resident is smoking.Facility provided document titled, Smoking Policy dated 07/03/25 which documents in part, facility staff may keep the residents smoking materials when not being used by the resident.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review the facility failed to maintain accurate records of usage and accountability for controlled substances on 1 of 6 medication carts for two (R201, R154) out of seven residents reviewed for medication storage. Findings Include: On 1/6/26 at 10:21AM, during the narcotic reconciliation count with V14 (Licensed Practical Nurse/LPN) on team's one cart, R201's Controlled Drug Administration Record Sheet documented seven (7) tablets were available. R201's medication blister card had six (6) tablets of Lorazepam 2mg. R154's Controlled Drug Administration Record Sheet documented twenty-nine (29) tablets. R154's medication card had twenty-eight (28) tablets of clonazepam 1mg. On 1/6/26 at 10:33 AM, V14 (LPN) stated, I gave R201's medication around 7:45 AM or 8:00 AM, I am not sure of the exact time. I gave 154's medication around 8:15 AM. I was trying to hurry up and pass my morning medications. I know I was sign out the medication after I administered the narcotic. Om 1/6/26 at 11:10 AM, V5 (Assistant Director of Nursing) stated, After the nurse administers medication, they are required to immediately sign out that medication on the appropriate documents. Controlled substance needs to sign out on the controlled medication sheet for a quick reference when a resident received the narcotic and narcotic accountability. Policy documented in part: Controlled Substance Prescriptions: dated 8/2020.Security and Record KeepingControlled substance, medications are stored at the facility under double lock or as required by state regulations, separate from all other medications and counted at each change of custody. The medication nurse on duty maintains possession of a key for controlled medications. Medication Pass dated 7/2/25.After medication is administered to each resident, sign the medication administration records that it was given.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide nectar thickened water as ordered by the physician and failed to follow the meal ticket for one resident (R49) in a total sample of 35.Findings Include: On 01/06/2026 at 11:54 PM, during lunch meal rounds observed R49 sitting in bed eating from his lunch tray. R49 had already consumed the main entree and was in the process of beginning to eat the mashed potato and cooked cabbage. The cooked cabbage had various thickness of strands of cabbage surrounded by a thin liquid pooling around the outside edges of the cabbage. It appeared as if the liquid used in the cooking process had separated from the cabbage. The cooked cabbage was not pureed. Observed a closed container of nectar thick apple juice on R49's tray and next to his meal tray was a large pitcher filled 1/3 full of ice and water. Observed R49 continue to eat the mashed potato and the cooked cabbage. Then, observed R49 put down his fork, remove the lid from the nectar thick apple juice container and drink the entire container of juice all at one time. R49 then proceeded to cough multiple times. R49 stated he likes to drink water and points to the pitcher next to his meal tray. R49 stated the staff put the ice in there and fill it with water. Then, R49 picked up the water pitcher, took a small sip from the straw and proceeded to cough again.On 01/06/26 at 11:56 PM, observed R49's meal ticket on the side of his meal tray which listed his diet order as Mechanical Altered/Ground, Nectar and listed in part for R49 to receive puree seasoned cabbage. On 01/06/26 at 11:58 AM, V30 (Registered Nurse) stated R49 is on nectar thick liquids because he has swallowing problems and is at risk for aspiration. V30 stated R49 gets water by himself from the bathroom. V30 observed R49's water pitcher filled 1/3 with ice. V30 stated the residents are not allowed to get ice by themselves, only the staff have access to the ice.On 01/6/26 at 12:06 PM, V31 (Certified Nursing Assistant) stated she is taking care of R49 today. V31 stated he is on nectar thick liquids which means he cannot tolerate thin liquids like the other residents so thickened liquids are sent for him on his meal tray. V31 stated she is the one who filled up R49's pitcher with ice and water this morning. V31 stated she is not able to thicken R49's water, that is only something the nurse care do, the CNAs are not allowed to do that. V31 viewed R49's water pitcher filled with ice and water and stated that water in the pitcher is not thickened.On 01/06/26 at 12:13 PM, V25 (Registered Dietitian) stated for residents on mechanical soft diets the consistency of the vegetable served is dependent what vegetable it is. V25 stated in some cases the vegetable may be pureed even if the resident is on a mechanical soft diet. V25 stated this is done to keep it safer for the residents. V25 stated the kitchen staff should follow the meal ticket and provide the food items in the consistency listed. V25 stated if the meal ticket says R49 should have received pureed cabbage then that is what he should have received. V25 stated if a resident is on nectar thick liquids, they should not have a pitcher of ice and water at the bedside because that is a thin liquid and places the resident at risk for aspiration. V25 stated because ice melts at room temperature it is considered to be a thin liquid and should not be provided to residents on nectar thick liquids. V25 stated water provided to residents on thickened liquids should be thickened to nectar consistency with no ice.On 01/07/26 at 2:35 PM, V24 (Speech Language Pathologist) stated she has been covering the facility since July 2025 and has been a Speech Language Pathologist for 20 years. V24 stated she last saw R49 in July 2025 at which time R49 was referred for a possible solid upgrade from mechanical soft to regular consistency. V24 stated at that time R49 he was already on a mechanical soft diet with nectar thick liquids. V24 stated R49 has been on this diet due to his diagnosis of COPD. V24 stated for some residents with COPD like R49 it means their swallowing can become dis-coordinated meaning sometimes the airway does not close off as it normally should when you swallow, or the airway closing can be sluggish. V24 stated during her bedside swallowing evaluation in July 2025 she could not establish a safe way to upgrade R49's diet consistency because R49 was very impulsive and eating large amounts of food at a fast pace. (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	01/09/2026

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.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V24 stated R49 has some cognitive deficits which did not make him a good candidate for education. V24 stated her recommendation was for R49 to continue a mechanical soft diet with nectar thick liquids. V24 stated thin liquids move too quickly and are harder to control. This is especially true if a resident like R49 who lacks awareness of their own abilities gulps or takes large sips of liquids, which can overwhelm their system. V24 stated nectar thick liquids are heavier and thicker and therefore moves slower through the swallowing system. V24 stated nectar thick liquids have a thicker viscosity which is why it is easier for people to swallow thickened liquids than thin liquids like water. V24 stated ice is a thin liquid because it melts to a thin liquid. V24 stated based on her bedside evaluation in July 2025 R49 should be receiving all liquids thickened to nectar consistency including water and should not have a water pitcher within his reach because he runs the risk of aspiration which has the potential to cause pneumonia. V24 stated yesterday, 01/06/25 afternoon the facility asked her to see R49 because staff found R49 drinking thin liquids. V24 stated she came to the facility yesterday afternoon and did an evaluation on R49 with water and determined that he would be allowed to have non-thickened water in between his meals, not with his meals. V24 stated the order to allow R49 water between meals was entered into R49's electronic health record (EHR) on 01/06/26 at 3:30 PM. V24 stated prior to this time R49 should not have been allowed to drink water/ice that was not thickened to nectar consistency because the doctor's order at the time the surveyor observed R49 eating lunch was for him to only receive nectar thickened liquids. V24 stated the kitchen should be following what is printed on the meal ticket. V24 stated strands of cooked cabbage even if cooked that has some thin liquid in it could be harder for R49 to chew/swallow. V24 stated if his meal ticket stated R49 should receive pureed cabbage that would be the safer option for R49 and that is what should have been served to him. V24 stated it is possible R49 could have swallowed finely ground small pieces of cooked cabbage if it was served with a gravy. V24 stated otherwise R49 should have received the pureed cabbage as printed on his meal ticket.On 01/07/26 at 3:55 PM, V25 stated on 01/06/26 when the surveyor observed R49 eating lunch R49 had an order for nectar thick liquids, and he should not have received or had access to ice or water (non-thickened). V25 stated prior to yesterday she was not made aware that R49 was non-complaint with water, otherwise she would have added that to his nutrition care plan.R49 diagnosis includes but not limited to Chronic Obstructive Pulmonary Disease, Dysphagia, Oropharyngeal Phase. R49's MDS (Minimum Data Set) dated 10/09/25 reveals R49 is severely cognitively impaired and requires a mechanically altered diet and complains of difficulty or pain with swallowing.R49's Order Summary Sheet dated 01/07/26 documents in part, diet order as mechanical soft texture, nectar thick liquids consistency order date 08/01/24.R49's Speech Therapy Discharge summary dated [DATE] documents in part aspiration precautions, soft/nectar thick liquids diet.R49's meal ticket dated 01/06/26, lunch listed mechanical altered/ground, nectar at the top of the meal ticket and listed in part pureed seasoned cabbage.R49's nutrition care plan initiated 03/22/22 documents in part, R49 risk to potentially choke or aspirate food or liquids and interventions include but not limited to prepare/serve the resident's nutritional diet as ordered. Prescribed diet is mechanical soft, nectar thick.Facility provided document titled, Diet Guide Sheet printed 01/07/2026, 9:02 AM which documents in part for Tuesday (Day 17) lunch mechanical altered/ground diet (to receive) pureed season cabbage.Facility provided kitchen policy titled, Thickened Liquids dated 10/01/25 which documents in part, thickened liquids will be made available to meet the nutritional and fluid needs of residents with dysphagia as ordered, to ensure residents receive thickened liquids meeting swallowing and food items that are liquid at room temperature must be thickened to desired consistency.Facility provided kitchen policy titled, Therapeutic Diets dated October 2019 which documents in part, it is the center policy to insure (ensure) that all residents have a diet order, including regular, therapeutic, and texture modified, prescribed by the attending physician, physician extender or credentialed practitioner in accordance with applicable regulatory guidelines.

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F 0576 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on interview and record review, the facility failed to provide mail services to residents on Saturdays. This has the potential to affect all 194 residents residing in the facility. Findings include: On 01/07/2026 at 10:34AM, during the resident council group meeting, R121, R144, and R186 states there is no mail delivered to the residents on Saturdays. Residents state when mail is first delivered, it is first checked by the front office, then the front office gives it to the receptionist, and then the receptionist gives it to the activity department, and then the activity department is who delivers mail to the residents. Residents state they have to wait until the weekdays to get their mail at the facility. Residents state sometimes their mail is opened when they receive it. On 01/07/2026 at 10:45AM, V9 (Receptionist) states he has been working at the facility for two to three years and states he only works at the facility Monday through Friday. V9 states when mail is delivered to the facility for the residents, he places the mail in a bin in the front office room. V9 states someone from the front office comes to the facility twice a week on Wednesdays, Thursdays, or Fridays to sort through the mail and disperse it to the residents. V9 states he does not work in the facility on the weekends and is not sure if mail is delivered to residents on the weekends. On 01/07/2026 at 1:33PM, V13 (Activity Director) states he has been working at the facility for one to two years and oversee 4 activity aides. V13 states 3 activity aides work Monday through Friday, and 1 activity aide works on the weekends. V13 states the activity aide scheduled to work on the weekends does not distribute the resident's mail to them. V13 states the protocol that is followed when resident mail is delivered is as follows: The receptionist places resident's mail inside a room at the front office, the mail is kept there until the front office sorts through it, once the front office sorts through it, the resident's mail is then given back to the receptionist. The activity aides pick up the resident mail from the receptionist desk and gives it to the residents. V13 states he was told by the front office that if residents receive mail, do not distribute it and hold it until Monday. V13 states on Mondays, there are more people in the front office to distribute the resident's mail. V13 states once the receptionist collects the resident's mail, the activity department has to wait for V11 (Admissions Director) or another front office staff member to distribute the resident's mail. V13 states the staff asks the residents to open their mail in front of staff in order to make sure there is no contraband delivered in the mail. V13 states mail is distributed to the residents approximately three days during the week. V13 states if residents inquire about their mail, then he directs them to the front office. V13 states sometimes when mail is given to the activity department, there is some mail that is opened already but the front office staff explains why it is opened already. V13 states the activity department then have the residents sign that they have received their mail. Facility census dated 01/06/2026 documents that a total of 194 residents reside in the facility. Long Term Care Ombudsman Program Residents' Rights dated 11/2018 documents in part, Your facility must deliver and send your mail promptly. Your facility may not open your mail without your permission.