

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008601	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/25/2025
NAME OF PROVIDER OR SUPPLIER CHALET LIVING & REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 7350 NORTH SHERIDAN ROAD CHICAGO, IL 60626		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigations: 2580715/IL185241 2581386/IL186670	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210a) 300.1210b) 300.1210d)3)6) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/21/25

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. This REQUIREMENT is not met as evidenced by: 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:	S9999			

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S9999	Continued From page 2 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. 1). R1's medical record (Face Sheet) documents R1 is a 62-year-old admitted to the facility on 6/11/24 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	S9999		

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S9999	Continued From page 3 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 fellow 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	S9999		

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S9999	Continued From page 4 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. 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	S9999		

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S9999	Continued From page 5 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:	S9999			

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S9999	Continued From page 6 - 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. 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	S9999		

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S9999	Continued From page 7 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 time 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. 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	S9999		

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S9999	Continued From page 8 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	S9999		

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S9999	Continued From page 9 in part, R4 is a 52-year-old admitted to the facility on 9/25/24 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.	S9999		

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S9999	Continued From page 10 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	S9999		

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S9999	Continued From page 11 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 52 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.	S9999		

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S9999	Continued From page 12 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. 3) R5's medical record (Face Sheet) documents R5 is a 30-year-old admitted to the facility on 11/11/24, 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	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008601	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 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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S9999	Continued From page 13 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	S9999		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008601	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/25/2025
NAME OF PROVIDER OR SUPPLIER CHALET LIVING & REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 7350 NORTH SHERIDAN ROAD CHICAGO, IL 60626		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 14 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. On 2/27/25 at 3:30 PM, R5 said it is not difficult for residents to get drugs in the facility. There is no plan in the facility on how to handle drug use before and after. There was a resident on 4th floor that overdosed twice. The resident came up to me on several occasions and asked if I had stuff (drugs). I am on Methadone and Suboxone. There are only two residents on methadone in the facility. There are no meetings or programs. If there was a narcotic anonymous or addiction assistance, I would attend. On 3/4/25 at 12:34 PM, V25 (Psychotherapist) said to be honest, I did not get to see R1 for individual therapy. I saw him once in group on 1/27/25. I met once with R4, he declined services (group/individual therapy). I have not seen R5 at all. "A"	S9999		