

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235361	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/20/2024
NAME OF PROVIDER OR SUPPLIER Chalet of Niles, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 911 S 3rd St Niles, MI 49120	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48637</p> <p>Based on interview and record review, the facility failed to thoroughly investigate and resolve grievances for one (resident #1) of three residents reviewed for grievance resolution, resulting in unresolved concerns and unmet needs.</p> <p>Findings include:</p> <p>Resident #1(R1)</p> <p>Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R1 admitted to the facility on [DATE] with diagnoses of diabetes, hypertension (high blood pressure) and cognitive communication deficit. Brief Interview for Mental Status (BIMS) reflected a score of 10 out of 15 which indicated R1's cognition was moderately impaired (8-12 is moderately impaired).</p> <p>The I Would Like to Know Form is the facility process for resident's and resident's representatives to file a concern/grievance. Review of R1's form dated 4/12/2024 showed it was filled out by Social Service Director (SSD) I on behalf of R1. The form revealed R1's question related to Indv(individual) stated on Thursday April 11th (night shift) CNAs (Certified Nursing Assistants) left indv in a soiled depends for 6 plus hours when changed. CNA did not cleanse periarea or put powder on her. CNA's did not change soaked bed. Indv mentioned having tape on her body but was unclear. Indv reported 2 hour wait time once call light was pressed. This form was assigned to Unit Manager (UM) G and under Results/Answer to Question it stated, Resident confirmed that 2 nurses answered her call light, 2 older white ladies and they didn't clean her properly and left her bed soiled. She stated she waited 4 plus hours to be changed. Stated they didn't use wipes to clean her periarea. The form also displayed that the question had been successfully answered and resolved on 4/12/2024 and a systemic or operational change rolled out as a result of the question. And Inservice provided to staff (verbally at the nurses station) about asking resident if satisfied with the care after providing care.</p> <p>During an interview on 6/20/2024 at 9:00 AM, R1 stated that she remembered the incident and said that it happened over the midnight shift but R1 couldn't remember all the details from that night besides having to wait a long time for help.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/18/2024 at 4:39 PM, SSD I stated that education was done with support staff regarding R1's I Would Like to Know Form dated 4/12/2024. SSD I' stated she wasn't sure what was done with the investigation since she just started that month so Nursing Home Administrator (NHA) A' helped with it.</p> <p>During an interview on 6/20/2024 at 10:05 AM, UM G stated that he only did an education with staff regarding no double briefing, 2 hour checks and change. UM G said this was verbal at the nurse's station at shift change so there wasn't any documentation.</p> <p>Review of the I Would Like To Know Policy with an updated date of 2/9/2016 revealed, Procedure 7. The assigned Dept (Department) Head should be prepared to share what has been done to date to answer/resolve that question/concern. This includes any interviews with staff or residents, or other activity (such as searching various areas or making phone contacts, etc) in an effort to define the root cause of the question/concern. 8. When the root cause is identified corrective action can be taken to resolve the issue as much to the satisfaction of the resident or the residence representative as possible.12. The question/concern and/or answer may require the intervention of the Admin (administrator), DON (Director of Nursing) and/or SSD (Social Service Director) in the course of the process or after the question/concern has been answered as a follow up and/or to show that the facility took genuine interest in their issue.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48637</p> <p>Based on interview and record review, staff failed to report an allegation timely to the Nursing Home Administrator and as a result to the State Agency, to law enforcement, and failed to report a concern/allegation to the State Agency for one resident (Resident #1) of three residents reviewed for abuse resulting in delayed reporting, an incomplete investigation and the resident not being protected from abusive individuals.</p> <p>Findings include:</p> <p>Resident #1(R1)</p> <p>Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R1 admitted to the facility on [DATE] with diagnoses of diabetes, hypertension (high blood pressure) and cognitive communication deficit. Brief Interview for Mental Status (BIMS) reflected a score of 10 out of 15 which indicated R1's cognition was moderately impaired (8-12 is moderately impaired).</p> <p>During an interview on 6/18/2024 at 3:30 PM, R1 stated that on 3/5/2024, Certified Nursing Assistant (CNA J) was trying to change her and the nurse {Licensed Practical Nurse (LPN) D}was helping and she was tossed into bed and almost hit her head on the bed frame.</p> <p>Review of the MI (Michigan) FRI (Facility Reported Incident) regarding R1's allegation revealed that the Incident Occurred on 3/5/2024 at 11:05 PM, it was Discovered on 3/6/2024 by Nursing Home Administrator (NHA) A at 10:20 AM and the initial report was submitted on 3/6/2024 at 11:18 PM and Law Enforcement was not notified.</p> <p>During an interview on 6/20/2024 at 7:12 AM, Licensed Practical Nurse (LPN) D stated that she waited until the next day to tell NHA A because the allegation that was made by R1 wasn't true since she was there and knew nothing happened.</p> <p>During an interview on 6/20/2024 at 8:48 AM, Sergeant H at the [NAME] Police Department stated that law enforcement should be called when there is any allegation of physical abuse which includes a staff member being rough with a resident.</p> <p>During an interview on 6/18/2024 at 2:13 PM, Nursing Home Administrator (NHA) 'A stated that her staff knows they must report an allegation right away to her but sometimes they don't report it immediately. NHA A also stated that she only reports harm or big incidents to the police. When asked if she reports to law enforcement when a resident alleges that a staff member was rough with them or they were hit, NHA A said no.</p> <p>During another interview on 6/20/2024 at 11:00 AM, NHA A stated that she found out about R1's allegation the next morning (3/6/20204) when she read it in morning report and she spoke to the nurse (LPN D) about her reporting the incident to her late.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The I Would Like to Know Form is the facility process for resident's and resident representatives to file a concern/grievance. Review of R1's form dated 4/12/2024 showed it was filled out by Social Service Director (SSD) I on behalf of R1. The form revealed R1's question related to, Indv(individual) stated on Thursday April 11th (night shift) CNAs (Certified Nursing Assistants) left indv in a soiled depends for 6 plus hours when changed. CNA did not cleanse periarea or put powder on her. CNA's did not change soaked bed. Indv mentioned having tape on her body but was unclear. Indv reported 2 hour wait time once call light was pressed. This form was assigned to Unit Manager (UM) G and under Results/Answer to Question stated, Resident confirmed that 2 nurses answered her call light, 2 older white ladies and they didn't clean her properly and left her bed soiled. She stated she waited 4 plus hours to be changed. Stated they didn't use wipes to clean her periarea. The form also displayed that the question had been successfully answered and resolved on 4/12/2024 and a systemic or operational change rolled out as a result of the question. And Inservice provided to staff (verbally at the nurses station) about asking resident if satisfied with the care after providing care.</p> <p>During an interview on 6/20/2024 at 9:00 AM, R1 stated that she remembered the incident and said that it happened over the midnight shift but R1 couldn't remember all the details from that night besides having to wait a long time for help.</p> <p>During an interview on 6/18/2024 at 4:39 PM, SSD I stated that education was done with support staff regarding R1's I Would Like to Know Form dated 4/12/2024. SSD I' stated she wasn't sure what was done with the investigation since she just started that month so Nursing Home Administrator (NHA) A' helped with it.</p> <p>During an interview on 6/20/2024 at 10:05 AM, UM G stated that he only did an education with staff regarding no double briefing, 2 hour checks and change. UM G said this was verbal at the nurse's station at shift change so there wasn't any documentation.</p> <p>Review of the State Agency Website for FRIs revealed this alleged neglect on 4/12/2024 wasn't reported.</p> <p>During an interview on 6/20/2024 at 11:00 AM, while discussing R1's I Would Like to Know Form dated 4/12/2024, Nursing Home Administrator (NHA) A stated if there was abuse/neglect that she would report this to the State Agency. NHA 'A also said that she can't find any documents regarding the education at shift change provided by UM G. During discussion, NHA A was aware this was considered alleged neglect and she wasn't able to provide an investigation into this concern. NHA A also said this wasn't reported to the State Agency.</p> <p>Review of the I Would Like To Know Policy with an updated date of 2/9/2016 revealed, Procedure 2. If the question/concern is related to alleged abuse and/or alleged neglect, then immediately follow the facility Abuse Policy and Procedure Protocol .</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Abuse Prevention Policy Program dated 10/22/2022 revealed, all personnel must promptly report any incident or suspected incident of resident abuse, mistreatment or neglect including injuries of unknown origin. Neglect is defined as, the failure to provide, or willful withholding of adequate medical care, mental health treatment, psychiatric rehabilitation, personal care or assistance with activities of daily living that is necessary to avoid physical harm mental anguish or mental illness of a resident. Under Procedure, must IMMEDIATELY report such incidents to the Charge Nurse, regardless of the time lapse since the incident occurred. The Charge Nurse will immediately report the incident to the Administrator or to the individual in charge of the facility during the Administrator's absence. Also, When an alleged or suspected case of abuse or neglect is reported to the Administrator, the Administrator, or person in charge of the facility, will notify the following persons or agencies of such incident immediately. 3. Law Enforcement Officials as per the Policy on reporting Reasonable Suspicions of a crime in LTC facility Section 1150B of the Social Security Act. Policy No (Number) 2.11a.</p>